Attachment 39

Image Trend Rollout Plan

ImageTrend:

Things to do prior to Piloting: (January 12- February 20)

Confirm Pilot Sites:

1. January 12 – January 16

    1. Finish the review of data elements (January 12 – January 30)
    2. Set validation rules to data elements (February 2 – February 13)
    3. Develop report templates (February 13- February 20)
    4. Set up and communicate roll out training session dates and locations (February 20 – March 1)

Piloting:

1. Bring in ImageTrend to provide education/training to piloting facilities (week of March 2- March 6)
2. 1st round of pilot (March 9-March 27)
3. Review of pilot to create changes and implementation of changes (March 30-April 3)
4. 2nd round of pilot reflecting implementation changes (April 6-April 17)
5. Follow up to ensure implementation changes are correct, if any additional changes to be made they will be done at this time(final system changes April 20-April 30) (final system April 30 to begin training/education)

Training/Education: "once we get to a final system" (May 1-June 30)

1. Develop education materials (May 1- May 8)
2. General state wide webinar to introduce the system (May 11 – May 15) (x3)
3. Strategically located sessions (6-10) for face to face following introduction to system (inviting quality/IT/Coordinators/Directors) (May 18- June 5)
4. One on One check in with each facility to ensure access and understanding of system (June 8- June 26)
5. Offering additional resources to facilities (verify prior to go live, provide ongoing support)

Go Live!!!

1. July 1, 2015

Attachment 40

Image Trend Pilot

ImageTrend Pilot-Trauma Data Registry System

The following provides a sequence of events and expectations related to hospital pilot testing of the ImageTrend Data Registry System. The following hospitals have agreed to pilot test the system:
Level 1:

- University of Iowa Hospitals and Clinics
- UnityPoint Iowa Methodist Medical Center

Level 2:

- Mercy Medical Center-Sioux City
- Genesis Medical Center-Davenport

Level 3:

- Trinity Regional Medical Center-Fort Dodge
- St. Luke's Hospital-Cedar Rapids
- Mercy Medical Center-Dubuque
- CHI Health Mercy-Council Bluffs
- Broadlawns Medical Center

Level 4:

- Monroe County Hospital
- Adair County Hospital
- Story County Medical Center
- Winneshiek Medical Center

ImageTrend will provide pilot hospital training on March 11th. Pilot hospital training will be provided in a web-based environment. It is anticipated the training will be approximately 2 hours in length. The session will be recorded if a pilot hospital is unable to attend the live training, it will be available later for review. In addition to the training, technical assistance will be provided throughout the pilot process.

The pilot will be conducted in two phases. Below are tentative dates for the testing.

- Conduct first phase of pilot testing. (March 14-April 1, 2015)
- Gather feedback from pilot sites on first phase of testing. Implement improvements based on that input. (April 2-April 7, 2015)
- Conduct second phase of pilot testing. (April 8-April 22, 2015)
- Gather feedback from pilot sites on second phase of testing. Implement final system improvements. (April 23-May 1, 2015)

The pilot process will focus on testing the following: movement of data from EMS forms and between trauma forms; review of form flow and requested data elements (or identification of missing data elements); review of performance improvement components of the system; and accessing data in the

system (pulling/developing reports). During each feedback session, IDPH will seek pilot hospital's perspective on the system performance, recommendations for system modifications, and feedback on important components to include in trainings.

The system has been set up with a "Trauma Short Form" and a "Trauma Incident Form." The "Trauma Short Form" aka short form is intended for us by hospitals that stabilize a trauma patient and transport that patient to definitive care. The "Trauma Incident Form" aka trauma form is intended for use by facilities providing definitive care to the trauma patient.

All data entered by the pilot hospitals during the pilot process will be deleted before the system goes live. Hospitals may use actual patient charts or factitious data when testing the system. Please attempt to utilize all aspects of the patient forms.

During Phase 1 of the Pilot:

- Level 1 and 2 trauma facilities are asked to:
    - Minimally enter 5 patients in the "Trauma Incident Form"
        - Look up and pull forward data from the two EMS records before completing the trauma form.
        - Minimally pull forward data from two short forms into the trauma form. IDPH will assist in developing and assigning short forms for use.
    - Utilize a report template (canned report) to develop a report using the system.
    - Develop a simple data report using the system.
    - Complete the evaluation provided by IDPH.
- Level 3 trauma facilities are asked to minimally enter 2 patients in the "Trauma Short Form" and 3 patients in the "Trauma Incident Form."
        - Look up and pull forward data from the two EMS records before completing the trauma form.
        - Minimally pull forward data from one short form into the trauma form. IDPH will assist in developing and assigning short forms for use.
    - Utilize a report template (canned report) to develop a report using the system.
    - Develop a simple data report using the system.
    - Complete the evaluation provided by IDPH.
- Level 4 trauma facilities are asked to minimally enter 4 patients in the "Trauma Short Form" and 1 patient in the "Trauma Incident Form."
        - Look up and pull forward data from the two EMS records before completing the short form.
    - Utilize a report template (canned report) to develop a report using the system.
    - Develop a simple data report using the system.
    - Complete the evaluation provided by IDPH.

During Phase 2 of the Pilot:

- Level 1 and 2 trauma facilities are asked to:
    - Minimally enter 3 patients in the “Trauma Incident Form”
        - Look up and pull forward data from one EMS record before completing the trauma form.
        - Minimally pull forward data from one short form into the trauma form. IDPH will assist in developing and assigning short forms for use.
    - Enter PI/Complications information for a minimum of 1 patient.
    - Utilize a report template (canned report) to develop a report
    - Develop a simple data report using the system.
    - Complete the evaluation provided by IDPH.
- Level 3 trauma facilities are asked to minimally enter 1 patient in the “Trauma Short Form” and 2 patients in the “Trauma Incident Form.”
        - Look up and pull forward data from one EMS record before completing the trauma form.
        - Minimally pull forward data from one short form into the trauma form. IDPH will assist in developing and assigning short forms for use.
    - Enter PI/Complications information for a minimum of 1 patient.
    - Utilize a report template (canned report) to develop a report
    - Develop a simple data report using the system.
    - Complete the evaluation provided by IDPH.
- Level 4 trauma facilities are asked to minimally enter 4 patients in the “Trauma Short Form” and 1 patient in the “Trauma Incident Form.”
        - Look up and pull forward data from one EMS record before completing the trauma form.
    - Enter PI/Complications information for a minimum of 1 patient.
    - Utilize a report template (canned report) to develop a report
    - Develop a simple data report using the system.
    - Complete the evaluation provided by IDPH.

IDPH/ImageTrend will provide technical assistance throughout the pilot process. Please capture screen shots for any data errors or functionality issues encountered whenever possible.

Attachment 41

American College of Surgeons Exit Summary

Iowa
Trauma System Consultation
February 2-5, 2015

System Consultation

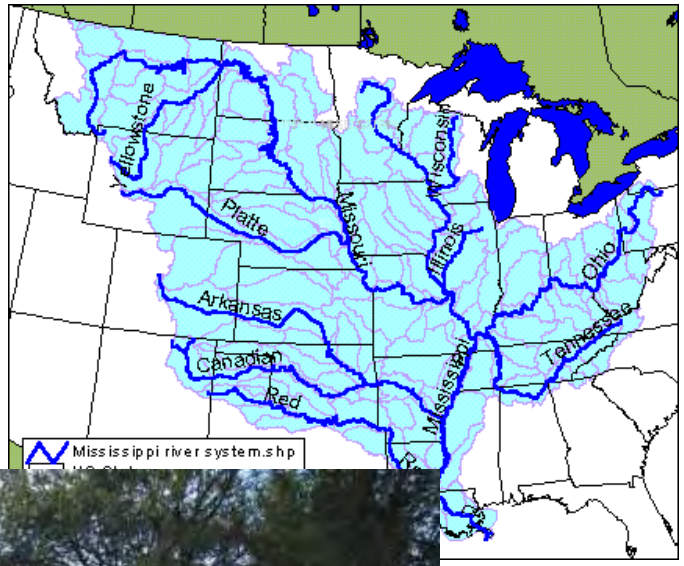
- Consultation, not verification
- Data collected through:
  - Review of questionnaire
  - Review of other available data
  - Interactive session with stakeholders
- Multi-disciplinary team
- Consensus-based process
- Recommendations derived independently

System Consultation

- Standard is an inclusive trauma system based on public health model (http://www.facs.org/trauma/hrsa-mtspe.pdf)
  - Goal is to decrease overall burden of injury
  - Integrate continuum of care
  - Broad-based regional approach
  - Data driven system evaluation and modification

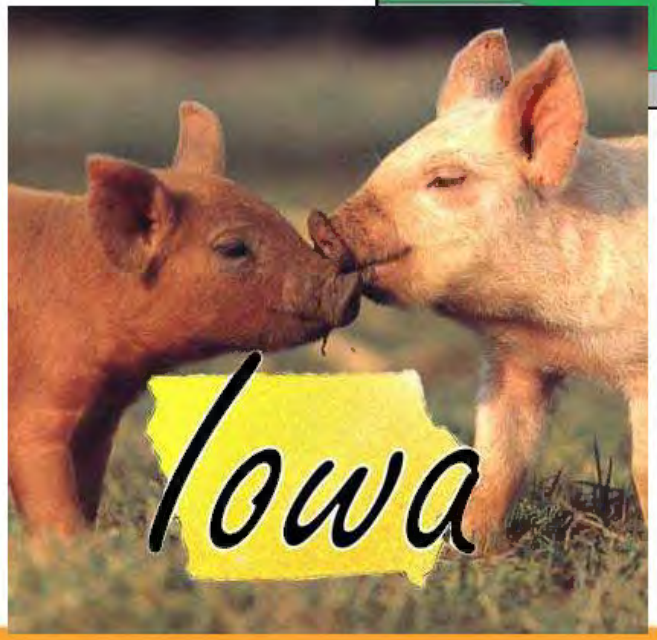

OUR LIBERTIES WE PRIZE AND OUR RIGHTS WE WILL MAINTAIN
IOWA

IOWA

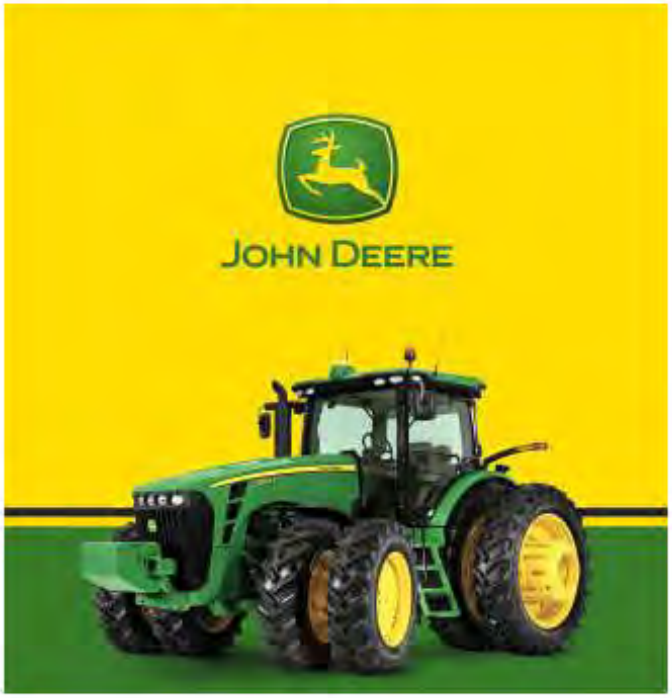

Yellowstone
Platte
Missouri
Illinois
Wisconsin
Ohio
Arkansas
Canadian
Red
Tennessee
Mississippi
Mississippi river system.shp

University of Northern Iowa
PANTHERS


IOWA ROCKS!
17 MILLION HOGS
CAN'T BE WRONG


Iowa

MUSCO Lighting



Wherever you are going to be, be there by midnight.

NOTHING GOOD HAPPENS AFTER MIDNIGHT.


3D
Show

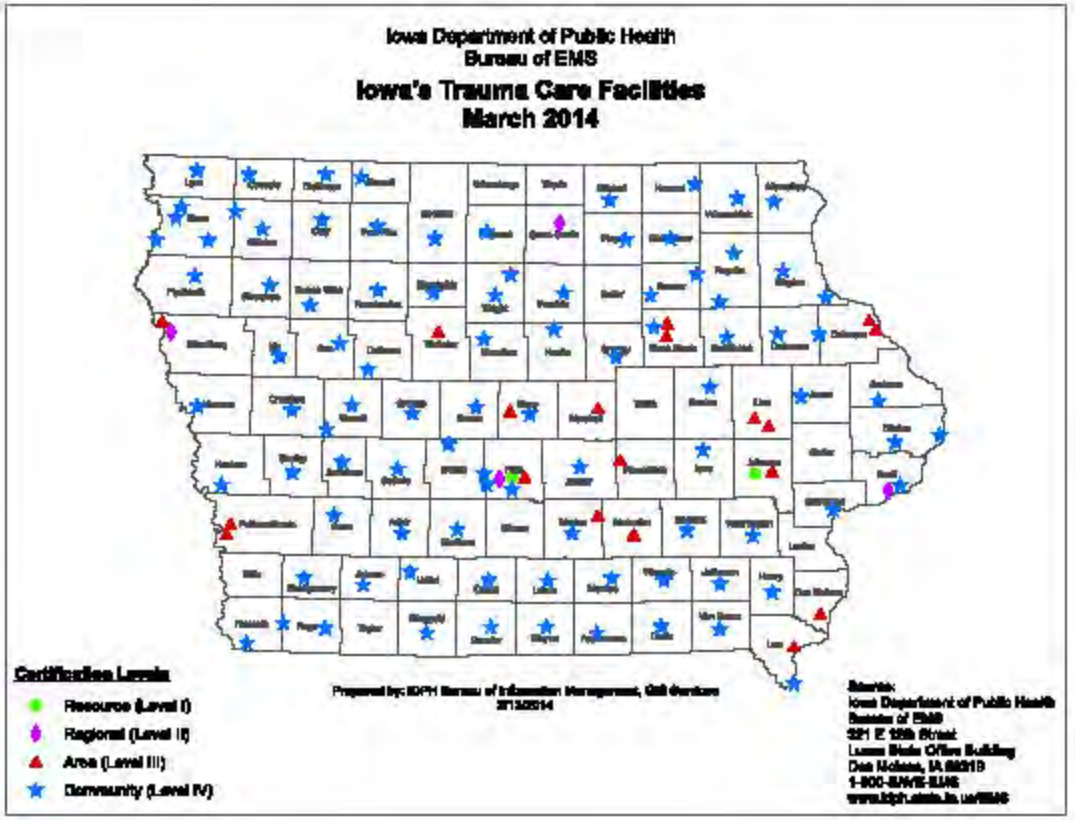

2011 12 28

Current Status

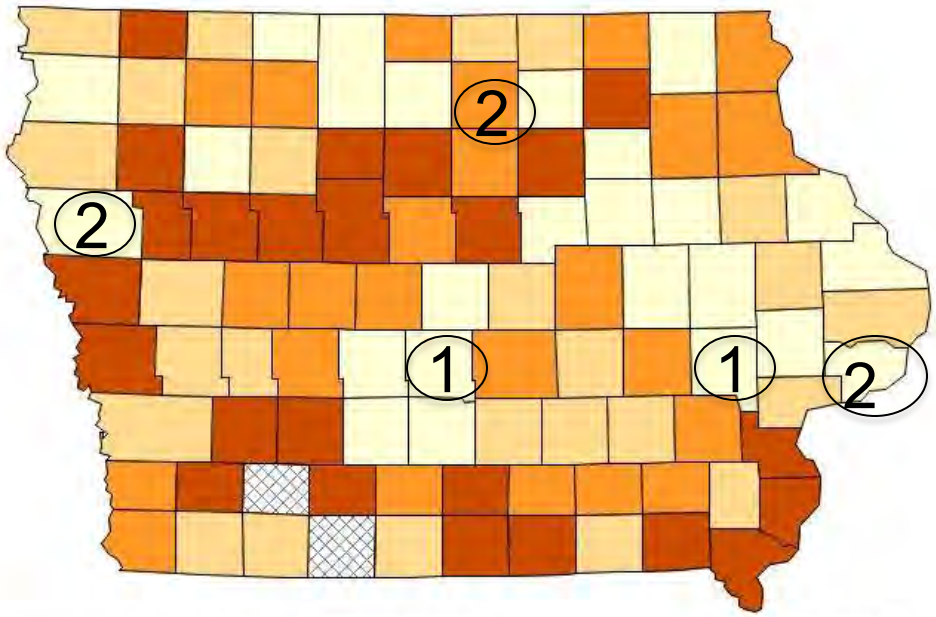
Iowa doesn't *have* a trauma system

Iowa *IS* the trauma system

Current Status



2004-2010, Iowa
Death Rates per 100,000 Population
All Injury, All Intents, All Races, All Ethnicities, Both Sexes, All Ages
Annualized Crude Rate for Iowa: 55.50



Suppressed/Unstable/Undefined
35.29-53.94
53.95-61.21
61.22-72.16
72.17-89.64

Reports for All Ages include those of unknown age.
* Rates based on 20 or fewer deaths may be unstable. These rates are suppressed for counties (see legend above); such rates in the title have an asterisk.

Produced by: the Statistics, Programming & Economics Branch, National Center for Injury Prevention & Control, CDC
Data Sources: NCES National Vital Statistics System for numbers of deaths; US Census Bureau for population estimates.

Current Status

- Inclusive system philosophy
- All acute care facilities categorized in the system
  - Verification process not robust
- Fledgling regional efforts
- Limited control of patient flow
- Limited system-wide analysis and PI

Current Status

- System development stalled
  - Coordinated leadership
  - Communication
  - Unity of effort
  - Perceived barriers to evaluating performance
  - Finances

Collaborate
Communicate
Constructive Framework

Our priority:
The best interest of the injured patient

Advantages and Assets

- Long history of dedicated participation
- Early adoption of inclusive system
- Legislative authority
- Committed stakeholders

Advantages and Assets

- Interest and engagement at IDPH
- Injury Prevention Research Center
- Engaged Medical Examiners
- Recognition change is necessary

Challenges and Vulnerabilities

- Lead agency priorities
- Patient flow
- Trauma Care Facility verification
- Hip fractures skew data analysis
- System-wide PI activity
  - Limited
  - Inhibits growth and development

Themes

- Old obstacles-new energy
- Strategic Vision
  - Trauma care facilities ≠ Trauma system
  - Inclusive system ≠ Unregulated system

Themes

- Regional development
- Leadership
- Transparency
- Gap analysis

Key Recommendations

Indicators as a Tool for System Assessment

- Complete an assessment of current system performance that can assist in system planning and serve as a baseline for ongoing system benchmarking.

Statutory Authority

- Create a broadly representative ad hoc subcommittee under the authority of the Trauma System Advisory Council to review all statutes and regulations pertaining to trauma with a focus on updating and/or revising sections needing attention.

- Codify into administrative rule the scope, function and rules of governance of the Trauma System Advisory Council.

- Enforce trauma rules consistent with statutory authority.

System Leadership

- Formalize communication channels/processes between the Department and TSAC.

- Establish a trauma/EMS medical director at IDPH.

Lead Agency and Human Resources

- Hire a full-time state trauma registrar.

Trauma System Plan

- Develop, within 18 months, a new State Trauma Plan using the Health Resources and Services Administration's (2006) Model Trauma System Planning and Evaluation document as a template.

Definitive Care

- Strengthen the hospital verification process for Level I, II and III.
  - Develop rules and procedures for remediation of deficiencies, lowering level of verification, and withdrawal of verification for hospitals not in compliance with standards.
  - Adopt the verification criteria specified in the most recent version of the ACS Resources for the Optimal Care of the Injured Patient document.
  - Develop a process to include comprehensive chart review in the verification site visit.
  - Utilize out of state reviewers.

Definitive Care

- Change the verification process for level IV hospitals to focus on technical assistance and facilitation of rapid triage and transfer of seriously injured patients, including resuscitation protocols, pre-identification of patient and injury types that will be transferred, and pre-selection of destination hospitals.

System Coordination and Patient Flow

- Update the current out-of-hospital trauma triage destination decision protocol.

- Develop specific “transfer out” criteria for Level III and Level IV trauma care facilities to identify the patient injury complexes that should lead to transfer to a higher level facility.

- Require each trauma care facility to have an agreement with an EMS agency (or agencies) to facilitate timely ground and air interfacility transport of trauma patients when needed.

System-wide Evaluation and Quality Assurance

- Evaluate the current PI protection statute and revise the rules to specifically include chart reviews within the PI and verification processes.

Trauma Management Information Systems

- Monitor implementation of the new EMS and trauma registry systems to identify and correct potential issues.

Observations

- This is a consultative process
  - The recommendations offered are based on broad general principles and experiences in other regions
  - The solutions will be unique and specific to Iowa
- Change is always difficult
- Progress will require a renewed commitment to ongoing collaboration by all stakeholders
- The solutions will be created by all of you
- DON'T WAIT!

ACS Review Team

• Jane Ball, RN, DrPH	ACS Consultant
• Amy Eberle, RN, BSN, EMT	Trauma Program Manager
• Stephen Flaherty, MD, FACS	Trauma Surgeon
• Douglas Kupas, MD, FACEP	Emergency Physician
• Fergus Laughridge, AEMT, CPM	State EMS Director
• Tara Leystra-Ackerman, MPH	ACS Staff
• Holly Michaels, MPH	ACS Staff
• Nels D. Sanddal, PhD, REMT	ACS Staff
• Robert J. Winchell, MD, FACS	Trauma Surgeon

Attachment 42

Trauma System Short Term Action Plan

Trauma System Short-term Action Plan

Verification Process

Assessment	Objective	Action/Activity	Target Dates/Expected Outcome	IDPH Lead & Current Status	Ongoing Evaluation
ACS has updated trauma facility criteria. Current Iowa criteria identified as inconsistent during re-verification process.	Update criteria by categorization level using ACS guidelines and evidence based information.	1. Develop draft of updated criteria for level IV facilities. Streamline criteria to provide black and white benchmarks. 2. Develop draft weights for identified Level IV criteria based on ACS criteria and TSAC leadership. 3. Coordinate with trauma partners to identify changes to other levels criteria based on delineation of levels to be verified by IDPH or ACS.	March 20, 2015-Draft Level IV weighted criteria available for review, comment, and discussion with trauma partners. Goal to have system review completed and final draft of Level IV weighted in third quarter of 2015. Criteria for other levels to be a discussion item at April 21, 2015 meeting to determine additional needs and timelines for completion.	Michelle-Ongoing	Evaluation of each level will occur minimally on a two year cycle. More frequent updates made as needed based on identified gaps, lessons learned, or changes in evidence based practice.
Through the review of current SACA submissions, identified current SACA is cumbersome, confusing, and does not request all data needed to confirm criteria have been met.	Re-develop SACA.	1. Develop self-assessment categorization application that streamlines the verification process. The application should only request information needed to verify criteria have been met. Application will flow in the same order as the criteria to expedite the review process.	March 20, 2014-Draft Level IV SACA available for review, comment, and discussion with trauma partners. Goal to have system review completed and final draft in third quarter of 2015.	Michelle-Ongoing	Evaluation of each level SACA will occur minimally on a two year cycle. More frequent updates made as needed based on identified gaps, lessons learned, or changes in evidence based practice.

Assessment	Objective	Action/Activity	Target Dates/Expected Outcome	IDPH Lead & Current Status	Ongoing Evaluation
Identified variances in reviews by verification team members. Insufficient staffing to meet verification needs.	Enhance the review teams.	1. Define qualifications for review team members and develop standardized application process. Ensure all documentation and contracts are in place for reviewers. 2. Develop policies/procedures for conducting a verification review. 3. Develop policy/procedure for conducting chart review during verification visit. 4. Develop and provide training for review team members.	1. March 20, 2015-application has been developed. Coordinating with team members to ensure documentation is in place. 2. March 20, 2015-Draft ready for trauma partner review. 3. March 20, 2015-Draft ready for trauma partner review 4. Training on current system for new verification team members to be completed by May 1, 2015. Training on updated verification process by fourth quarter 2016.	Michelle-Ongoing Michelle-ongoing Michelle-ongoing Michelle-ongoing	Verification team training/continuing education will occur annually. Contracts will be maintained on a three year cycle.
Verification process is not clearly defined in policies/procedures. Administrative rules require updates to reflect progression in trauma system, i.e. chart review and	Update and clarify verification process.	1. Clarify verification process to include onsite visits at level IV facilities, ACS verification of more than level I facilities, etc.	1. Draft materials to trauma partners in mid-March. Request written feedback from partners after distribution and item for discussion at April 21, 2015 meeting to determine additional	Diane-ongoing	Administrative rules will be reviewed/updated minimally on a five year cycle. More frequent updates made as needed based on identified gaps, lessons learned, or changes in evidence based practice.

Assessment	Objective	Action/Activity	Target Dates/Expected Outcome	IDPH Lead & Current Status	Ongoing Evaluation
clarifying disciplinary actions.		2. Draft Chapter 134-Trauma Care Facility Categorization and Verification to clearly articulate verification process, chart review, and disciplinary action process. Ensure review by IDPH Assistant Attorney General. 3. Complete draft of Chapter 138-TSAC to clearly articulate TSACs and subcommittees roles and responsibilities.	timelines. 2. Draft materials to trauma partners by April 15, 2015. Request written feedback from partners after distribution and item for discussion at April 21, 2015 meeting to determine additional timelines. 3. Draft materials to trauma partners by April 15, 2015. Request written feedback from partners after distribution. Materials to be discussed at April 21, 2015 meeting to determine additional timelines.	Diane-ongoing Diane-ongoing	
Identified through interactions with trauma partners and through the ACS consultation, there are partners desiring to be actively engaged in trauma system activities with varying perspectives.	Obtain feedback from constituency and implement changes	1. Provide verification materials to constituency for review. Groups to include: TSAC, Iowa Trauma Coordinators, Iowa Hospital Association. 2. Gather feedback and recommendations from constituency related to verification. 3. Implement changes to	Process and timelines to be established after April 21, 2015 meeting.	Diane/Michelle -not started	Evaluation of verification materials will occur minimally on a two year cycle. More frequent updates made as needed based on identified gaps, lessons learned, or changes in evidence based practice.

Assessment	Objective	Action/Activity	Target Dates/Expected Outcome	IDPH Lead & Current Status	Ongoing Evaluation
		verification materials to build consensus.			
Administrative rules require updates to reflect progression in trauma system.	Update administrative rules and implement improved processes	1. Final IDPH administrative approval verification process, materials, and administrative rules. 2. Final approval of administrative rules by Heather. 3. Submission of administrative rules for adoption. 4. Implement administrative rules and associated processes.	Process and timelines to be established after April 21, 2015 meeting.	Diane-not started Diane-not started Diane-not started Diane-not started	Administrative rules will be reviewed/updated minimally on a five year cycle. More frequent updates made as needed based on identified gaps, lessons learned, or changes in evidence based practice.

Data System

Assessment	Objective	Action/Activity	Target Dates/Expected Outcome	IDPH Lead & Current Status	Ongoing Evaluation
Current trauma data registry is antiquated. Iowa needs a data system to effectively capture valid data for use in quality improvement and system evaluation.	Review and customize trauma data registry.	1. Work with ImageTrend and trauma nurse coordinators to customize the system. 2. Secure funding and hire temporary employee (trauma data registrar) to assist with system development and rollout. Block grant funding request sent for consideration. 3. Develop report templates with ImageTrend. 4. Set up and communicate rollout training session dates and locations.	1. March 10, 2015-Develop a system ready for pilot testing. 2. ASAP-exploring funding stream to hire temporary staff support. 3. March 10, 2015 4. March 10, 2015	Diane -Ongoing Gerd, Ken, Rebecca - Ongoing Diane-ongoing Diane-ongoing	Minimum of quarterly review of data submissions to ensure timely data entry. Annual evaluation of data through system evaluation and quality improvement processes to identify data concerns or gaps. Development of annual training/continuing education to ensure data integrity.
Essential the new data system is customized to meet needs of trauma data system end users.	Pilot trauma components of ImageTrend	1. Identify and gather system user information for pilot sites. 2. Provide system training (ImageTrend to provide) to the pilot sites. 3. Conduct first round of pilot testing. 4. Gather feedback from pilot sites on first round of testing. Implement improvements based on that input. 5. Conduct second round of pilot testing.	1. March 5, 2015-Identify needed information to establish pilot sites in ImageTrend 2. By March 13, 2015-complete pilot site training 3. March 14-April 1-test and evaluate the trauma registry. 4. April 2, 2015-provide feedback to IDPH on system improvements and implement those improvements. 5. April 8-April 22-test and	Diane-Ongoing ImageTrend-ongoing Pilot hospitals-Not started Diane-not started Pilot hospitals-	Evaluations completed by pilot hospitals will be reviewed. System improvements will be implemented based on pilot hospital evaluations.

Assessment	Objective	Action/Activity	Target Dates/Expected Outcome	IDPH Lead & Current Status	Ongoing Evaluation
		6. Gather feedback from pilot sites on second round of testing. Implement final system improvements. 7. Identify final system to be implemented on July 1, 2015	evaluate the trauma registry. 6. April 23, 2015- provide feedback to IDPH on system improvements and implement those improvements. 7. By May 1, 2015, finalize the trauma registry system to begin development of training materials for statewide rollout.	not started Diane-Not started Diane-Not started	
Trauma registry data could be improved with increased and consistent use of the electronic statewide data system.	Complete statewide training and education for trauma data registry	1. Develop education materials based on the finalized Iowa system and lessons learned from pilot testing. 2. Provide three statewide webinars to introduce the system to users. 3. Conduct strategically located sessions for face-to-face training…inviting quality/IT/coordinators and directors) 4. Conduct one-on-one check in with each facility to ensure access and understanding of system and provide additional information and training as needed.	1. By May 18, 2015-develop training materials for statewide rollout of trauma registry. 2. May 11-15, 2015-IDPH to provide overview of trauma registry system via statewide webinars. 3. May 18-June 18, 2015-complete statewide training on registry system. 4. June 18-June 30, 2015-complete follow up with each facility to identify any ongoing training/technical support needs in preparation of the	Diane-Not started Diane-Not started Diane-Not started Diane-Not started	Minimum of every other monthly review of data submissions to ensure timely data entry. Annual evaluation of data through system evaluation and quality improvement processes to identify data concerns or gaps. Development of annual training/continuing education to ensure data integrity.

Assessment	Objective	Action/Activity	Target Dates/Expected Outcome	IDPH Lead & Current Status	Ongoing Evaluation
		5. "Go Live"	system going live. 5. July 1, 2015-Initate use	All Hospitals	

System Assessment/System Benchmarking

Assessment	Objective	Action/Activity	Target Dates/Expected Outcome	IDPH Lead & Current Status	Ongoing Evaluation
Identified through the ACS visit, Iowa has not completed a statewide system assessment.	Identify system assessment tool to be utilized	Determine what assessment tool will be utilized for benchmarking. Options include: • ACS Benchmarks, Indicators and Scoring (BIS) tool from Health Resources and Services Administration's Model Trauma System Planning and Evaluation-very long, cumbersome, somewhat confusing • Utilize the optimal elements from the above tool that were gathered for the ACS visit…gathered via SurveyMonkey…not a high response rate and responses didn't demonstrate understanding of the question(s). • Other to be determined…state developed version or assessment tool used by another State.	Process and timelines to be established after April 21, 2015 meeting.	Michelle-ongoing	Annual review of assessment benchmarks. Annual action plan to implement system improvements.

Identified through the ACS visit, Iowa has not completed a statewide system assessment.	Completion of assessment tool	Determine if assessment tool will be: • Completed by a committee/subcommittee • Responses from all hospitals/trauma partners • Survey vs. face-to-face/webinar	Process and timelines to be established after April 21, 2015 meeting.	Michelle -not started	Annual review of assessment benchmarks. Annual action plan to implement system improvements.
Identified through the ACS visit, Iowa has not completed a statewide system assessment. Currently unable to benchmark system improvement against a statewide system assessment.	Identification of benchmarking process	Develop a process, schedule and data requirements for annual benchmarking of progress.	Process and timelines to be established after April 21, 2015 meeting.	Michelle-not started	Annual review of assessment benchmarks. Annual action plan to implement system improvements.

Strategic Plan

Assessment	Objective	Action/Activity	Target Dates/Expected Outcomes	IDPH Lead & Current Status	Ongoing Evaluation
Identified through the ACS visit, Iowa does not have a current strategic plan for the trauma system.	Identification of system priorities-full spectrum of the system.	1. Identify trauma system representatives to engage in development of the strategic plan. 2. Review findings from the benchmarking/assessment process to identify gaps and areas of improvement. 3. Consider a SWOT analysis (Strengths, weaknesses, Opportunities, and Threats) with trauma system representatives. 4. Identify system priorities to be included in the strategic plan. Ensuring engagement of all components of the trauma system. 5. Develop timelines, responsible parties, and benchmarks for identified priorities.	Process and timelines to be established after April 21, 2015 meeting.	Diane-Not started	Annual review of strategic plan. Annual documentation of achievements and challenges in meeting goals of the strategic plan. Develop a new trauma system strategic plan on a ten year rotation.
Identified through the ACS visit, Iowa does not have a current strategic plan for the trauma system.	Development of the strategic plan.	1. Develop draft plan based on information gathered. 2. Provide strategic plan draft to development team for review and comment. 3. Implement changes based upon provided feedback. 4. Develop Department	Process and timelines to be established after April 21, 2015 meeting.	Diane-Not started	Annual review of strategic plan. Annual documentation of achievements and challenges in meeting goals of the strategic plan.

		approved final Strategic Plan document. 5. Distribute plan to statewide trauma partners with understanding of process to monitor implementation of the plan.			Develop a new trauma system strategic plan on a ten year rotation.

Advisory Council/Committees/System QI

Assessment	Objective	Action/Activity	Target Dates/Expected Outcome	IDPH Lead & Current Status	Ongoing Evaluation
Membership engagement at TSAC meetings has been limited as identified in meeting attendance.	Ensure all positions of the TSAC are filled with engaged partners.	1. Draft letter to association/society with open position to identify new representative for TSAC. 2. Develop draft letter to association/society for positions opening July 1, 2015 to identify representative for TSAC.	1. March 6, 2015-Initiate processes to ensure all TSAC positions are filled. 2. May 1, 2015-Ensure all TSAC positions are filled with individuals interested in the betterment of the trauma system.	Diane-ongoing Diane-ongoing	Quarterly evaluation of membership engagement in meetings to ensure representation from across the system.
As identified during the ACS consultation, committee roles, responsibilities, and communication pathways need to be clearly identified, documented, and educated.	Identify sub-committees and committee roles/responsibilities. (membership)	1. Identify sub-committees of TSAC. 2. Identify and document mission and scope of sub-committees. 3. Identity sub-committee membership and membership participation requirements.	Process and timelines to be established after April 21, 2015 meeting. Expected sub-committees will be established with: • Defined mission and scope • Defined membership	Diane -ongoing	Annual review of sub-committees to confirm ongoing need, modifications to committee mission and scope, and to evaluate committee membership.
As identified during the ACS consultation, committee roles, responsibilities, and communication pathways need to be clearly identified, documented, and educated.	Educate TSAC members to the purpose of the committee, membership roles and responsibilities.	1. Identify and document the role of TSAC and associated subcommittees. 2. Review committee leadership. 3. Identify communication pathways. 4. Identify and communicate committee expectations.	Process and timelines to be established after April 21, 2015 meeting. Expected outcomes: • Discussion of committee mission and scope. • Identify communication pathways. • Determine	Ken-ongoing	Quarterly evaluation of membership engagement in meetings to ensure representation from across the system. Annual review of committee mission and scope, committee member roles and responsibilities, and communication pathways for

			mechanism to educate membership on roles and responsibilities.		new members.
IDPH and trauma partners have identified through review of previous activities and based on committee work, the need to improve quality improvement assessment and implementation of findings.	Identify process for system quality improvement both statewide and sub-state. (benchmarking)	1. Engage with the System Evaluation Quality Improvement Sub-committee (SEQIS) to identify quality improvement indicators/benchmarks. Consider BIS assessment review findings. 2. Determine process for conducting sub-state quality improvement/ Performance improvement reviews. 3. Develop strategies for system improvement 4. Implement improvement strategies. 5. Develop strategies to evaluate improvement activities.	1. Process and timelines to be established after April 21, 2015 meeting. Expected outcome is a completed assessment tool. 2. Process and timelines to be established after April 21, 2015 meeting. Expected outcome of a robust quality improvement process utilized to impact improvements.	Michelle - ongoing Michelle -not started	Annual review of assessment benchmarks. Annual action plan to implement system improvements.

Attachment 43

Iowa EMS Agenda for the Future

EXECUTIVE SUMMARY

Mission Statement of the Iowa Department of Public Health's (IDPH) Bureau of Emergency Medical Services (EMS):

'Promoting and protecting the health of Iowans through EMS'

As the lead agency for EMS, the IDPH's Bureau of EMS provides leadership and resources to promote and protect the health of Iowans through prevention, acute care, and rehabilitation of the ill and injured.

Iowa's EMS Agenda for the Future establishes a vision for emergency medical services (EMS) in Iowa. The document addresses the 14 attributes presented by the National Highway Traffic Safety Administration's *EMS Agenda for the Future*. Iowa's EMS Agenda outlines goals and identifies activities necessary to achieve those goals. The Bureau of EMS has already met several of the goals and will continue to monitor and update them as needed.

Meeting the goals will not be easy. Individuals, organizations, EMS agencies, and others will be responsible for creating the future of EMS in Iowa. Participation at local, county, regional and state levels will be critical if EMS is to take a lead role in caring for the health care needs of Iowa's communities. All of those with a stake in the future of EMS must participate.

Health care is changing rapidly, and EMS care is no exception. Volunteerism can no longer sustain a full-time ambulance service in every community, and advancing technology and increasing national standards for training and certification are increasing the standard of patient care. Collaborative EMS system development is essential for its survival, especially in rural areas. Data provided to the Bureau by ambulance services will support improved system design and enable more timely access to the care needed for life-threatening injury and illness. The benefit for Iowans is improved access to more efficient and effective emergency services. Such endeavors have a great potential to reduce suffering, disability, death, and costs. The benefit for Iowa's EMS system is to reduce the burden of the volunteer.

TABLE OF CONTENTS

EMS System Attributes:

INTEGRATION OF HEALTH SERVICES

Integration of health care services helps to ensure that the care provided by EMS does not occur in isolation, and that positive effects are enhanced by linkage with other community health resources and the health care system as a whole.

EMS provides out-of- hospital medical care to those with perceived urgent needs as a component of the overall health care system. EMS delivers treatment as part of, or in combination with, systematic approaches intended to reduce morbidity and mortality for specific patient sub-populations.

GOALS

1) **Integrate the role of EMS in public health into the health care system.**
   Bureau Activities:

- As necessary, redefine the EMS providers' role in the delivery of community health care as the system continues to evolve and mature.
- Develop simple cost-effective mechanisms to conduct uniform, on-going local EMS system assessment.
- Collect and distribute EMS system "best practices" that provide models of integration.
- Ensure the Bureau of EMS and local public health agencies are integrated into local mass casualty plans to assist with resource management.

2) **Integrate EMS with other health care providers and provider networks to assure a seamless continuum of care.**
   Bureau Activities:

- Develop an educational program suitable for all health care providers to explain the capabilities and resources of EMS.
- Facilitate the delivery of the educational program throughout the system to all health care providers.
- Continue to encourage EMS providers to connect with their local boards of health.

EMS RESEARCH

Research is the key to the development of effective EMS Systems in Iowa and to ensure that the best possible patient care is provided in the out of hospital setting.

Only through research can we begin to evaluate the way we deliver emergency medical care in the out of hospital setting. As the lead agency for EMS, we must support scientific research and develop ways to make it easier to accomplish.

Research involves pursuit of the truth. In EMS, its purpose is to determine the efficacy of emergency medical care and improve care and allocation of resources.

GOALS

1) **Work with the EMS Advisory Council and state academic institutions in support of EMS research.**

Bureau Activities:

- Promote high standards of care by requiring that any changes in new procedure, devices or drugs are based upon scientific evidence.
- Support funding for scientific EMS research.
- Support the use of uniform electronic data collection, data linkage and reporting mechanisms that allow patient outcomes to be gathered and analyzed.
- Monitor issues identified in NHTSA's National EMS Research Agenda.

LEGISLATION AND REGULATION

Legislation is central to the provision of EMS. It affects EMS funding, system designs, research, and EMS personnel certification, service program authorization, Trauma Care Facility verification and scope of practice.

GOALS

1) **Serve as the lead agency for the statewide EMS system**

2) **Secure continuous funding for the Bureau of EMS, by legislation, enabling the bureau to carry out leadership responsibilities.**

Bureau Activities:

- Identify and serve as a resource for key legislative proposals.
- Work closely with the Department legislative liaison and other health care organizations and associations.
- Support any legislation changing state code that directs county governments to provide emergency medical care to their entire population.

SYSTEM FINANCE

Emergency medical systems, like all public and private organizations, must be financially viable. In an environment of constant economic flux, it is critical to continuously strive for a solid financial foundation.

GOALS

1) **Seek new funding for state, regional, or county system development to ensure continued delivery of care.**

Bureau Activities:

- Strive to expand future funding sources.
- Support legislative initiatives for improved EMS funding.
- Establish and renew private/public partnerships.
- Continue to enhance existing state-wide EMS grant programs.
- Maintain a public awareness of the need for EMS funding.

HUMAN RESOURCES

The task of providing quality EMS care requires qualified, competent, and compassionate people. The human resource, composed of a dedicated team of people with complimentary skills and expertise, is the most valuable asset to EMS patients.

GOALS

1) **Support recruitment, retention, and leadership training of volunteer and career EMS providers.**

   Bureau Activities:

- Analyze and track recruitment and retention efforts statewide and develop statewide plans for improvement
- Partner with local EMS systems, fire departments and community agencies to develop incentive programs to recruit and retain volunteers and to develop a culture of volunteerism and community service.

2) **Support sufficient EMS Bureau staffing to provide direction and leadership in:**

   EMS provider certification;
   Grant administration;
   Disaster response;
   Emergency response;
   Regulation/disciplinary actions;
   Education and training;
   Service program authorization;
   Trauma system development and maintenance;
   Data management;
   Emergency medical services for children;
   Injury prevention/health promotion;
   EMS system development;
   Public Access Defibrillation.

3) **Ensure that alterations in expectations of EMS personnel to provide health care services are preceded by adequate preparation.**

4) **Provide continual education that focuses on national changes of standards and trends within EMS.**

5) **Ensure statewide dissemination of "EMS in Iowa" presentation to provide awareness of updated EMS standards and trends.**

MEDICAL DIRECTION

Medical oversight means granting authority and accepting responsibility for the care provided by an EMS service or system. Quality medical oversight is an essential process to provide optimal care.

GOALS

1) **Fund a state EMS Medical Director.**

Bureau Activities:

- Develop a job description defined by consensus of EMS related professionals and state EMS organizations.

2) **Formalize relationships between the Bureau and the EMS service/system medical directors.**

Bureau Activities:

- Assist in providing and maintaining technical assistance resources for the EMS Medical Director (data collection, research).
- Provide all EMS physician medical directors with initial and on-going training on their roles and responsibilities.

EDUCATION SYSTEMS

As EMS care continues to advance, the need for consistently high quality education for EMS personnel increases. Education programs must meet the needs of new providers and the seasoned professional, who must maintain and enhance skill and knowledge with advancing technology and science.

GOALS

1) **Ensure the quality and consistency of the process and outcome of EMS education.**

Bureau Activities:

- The Bureau shall develop and conduct EMS-Instructor and EMS-Evaluator programs.
- Perform site visits of training programs, evaluating their adherence with nationally recognized standards for the training of emergency care providers.
- Develop and disseminate evaluation models for EMS training programs.
- Support training programs seeking national accreditation.
- Implement direct communication with EMS training programs with emerging telecommunication technology while encouraging the communications between the training programs and their instructors and evaluators.
- Adopt national standards for education core-content objectives.

2) Assist in making educational opportunities available throughout the state.

Bureau Activities:

- Evaluate various education formats, including distance and interactive self-learning, by applying existing and developing technology.
- Maintain bridge curriculums.
- Develop curriculums bridging between health-care professions.

- Pursue funding opportunities to provide education in underserved areas.

3) **Develop continuing education standards that assist emergency medical care providers in maintaining competency.**
   Bureau Activities:
- Work with partners to ensure that continuing education requirements are realistic and adequate.
- Integrate renewal requirements with service program CQI process.

4) **Maintain a valid, secure, fair, transportable and defendable certification process.**
   Bureau Activities:
- Implement centralized practical and written certification testing.
- Standardize the mechanisms used to verify the competency of and issue credentials to EMS personnel.
- Eliminate legal barriers to intra and interstate reciprocity of EMS provider credentials.
- Develop core evaluators to ensure consistent practical.

PUBLIC EDUCATION

Public education, as a component of health promotion, is a responsibility of every health care provider and institution. It should provide a combination of learning experiences to facilitate voluntary actions leading to health.

GOALS

1) **During each fiscal year, engage in continuous Public Information and Education (PIE).**
   Bureau Activities:
- Include the principles of prevention and its role in improving community health in EMS education core content.
- Conduct public education programs on EMS and injury prevention.
- Improve the ability of EMS to document injury and illness circumstances.

2) **Continually maintain and expand a central repository of EMS public education.**
   Bureau Activities:
- Distribute information about EMS and injury prevention to a variety of audiences.

3) **Annually seek and support PIE initiatives and funding.**

4) **Utilizing various partnerships, develop and maintain annually a network for EMS public education.**
   Bureau Activities:
- Ensure state-wide dissemination of public information and educational opportunities through annual evaluation of programs and activities.

- Assess usage of public information and educational opportunities through yearly evaluation of programs and activities.
- Work with media on EMS issues and injury prevention.

5) Yearly utilize collaborative partnership to support EMS legislative processes initiatives.

Bureau Activities:

- Assist health-care providers and the public by disseminating information on pending EMS legislation on an ongoing basis.
- Prepare briefings for media, legislators, and community groups on EMS and injury prevention.

PREVENTION

Prevention is the responsibility of every health-care practitioner.

GOALS

1) Collaborate with community agencies and health-care providers with expertise and interest in illness and injury prevention.

Bureau Activities:

- Support and enhance program initiatives and develop new programs according to state-wide needs.
- Integrate injury-prevention education in EMS systems through initial and continuing education programs at the local, regional and state level.
- Through assessments, data systems and the patient-care registry, identify state, regional, and community injury-prevention needs.
- Serve as a state-wide prevention resource network.
- Develop public and private partnerships to support initiatives.

2) Develop and maintain a prevention-oriented atmosphere within EMS systems.

Bureau Activities:

- Include the principles of prevention and its role in improving community health in the EMS providers' role and responsibility.
- Include prevention education in the "EMS In Iowa" presentation.
- Increase EMS provider awareness of injury and illness prevention.
- Support legislation that results in injury and illness prevention.
- Make data on injury and illness trends available to state stakeholders..
- Identify key elements in such data for development of policy language.
- Establish funding sources for prevention initiatives.
- Seek resources from foundations and grants.
- Develop partnerships with other Federal, state and local agencies for funding and implementation of future prevention plans.
- Make injury and illness prevention an EMS based service role through education and training.

PUBLIC ACCESS

The focus of public access is the ability to obtain prompt and appropriate EMS care regardless of socioeconomic status, age, or special need. For those who contact EMS with a perceived emergency medical need, the response and level of care must be commensurate with the situation.

GOALS

1) **Support continuation of 9-1-1 statewide.**

2) **Continue to support the implementation of a system requiring that all calls to a dispatch center, regardless of origin, are automatically accompanied by location-identifying information.**

   Bureau Activities:

- Support a statewide rural addressing system.
- Endorse a system to provide 9-1-1 telephone service for those unable to afford it.

3) **Continue support for a uniform cellular 9-1-1 service that reliably routes calls to appropriate dispatch centers.**

   Bureau Activities:

- Support cell-phone transmission of dispatch-center information.

4) **Support EMS-systems capacity to triage calls, and provide resource allocation tailored to patient needs.**

   Bureau Activities:

- Support mandatory EMD certification.
- Support the structuring of EMS boundaries that ensures timely patient care response.

5) **Integrate Intelligent Transportation System (ITS) technology into the EMS system.**

   Bureau Activities:

- Identify ITS technology useful for EMS.
- Work with public and private stakeholders to support EMS-ITS infrastructure development, including wireless caller-location technology.
- Include EMS needs in the Iowa DOT ITS Service Deployment Plan.
- Develop a mechanism to implement appropriate ITS technology in EMS systems and monitor its effectiveness.

COMMUNICATIONS SYSTEMS

Effective communications steer all organizations, including EMS systems, providing transfer of information to enable decisions.

GOAL

1) Support exploration of the uses of new communications technology by EMS.

CLINICAL CARE

EMS responds to those with perceived emergency needs and, when indicated, provides care and transportation to, from, and between health-care facilities. Mobility and immediate availability to the entire population distinguish EMS from other components of the health-care system.

GOALS

1) **Ensure that a minimum standard of care is met in every community.**
   Bureau Activities:
   - Update protocols through the Quality Assurance Standards & Protocols (QASP) sub-committee of the EMS Advisory Council on at least an annual basis.
   - Ensure all services to use the state-wide EMS protocols as a minimum standard with a mechanism to approve changes requested by program medical directors.
   - Formalize a way to consider incorporating non state-wide EMS protocols (enhancements, additions, etc.) into the state-wide protocols.
   - Formalize a way to forward any variation from the state-wide EMS protocols to outside peer review (bureau medical director/staff, QASP, etc.).

2) **Review of research on new care techniques and technology.**

3) **Establish collaborative networks with all potential transport systems.**

4) **Identify training and needs for disaster preparedness (biological, chemical, nuclear, etc.) of various state and local agencies into the EMS system.**

5) **Enhance the quality of end of life (EOL) care in Iowa.**

INFORMATION SYSTEMS

All data collection efforts by the Bureau of EMS will be purposeful and timely. The Bureau of EMS is committed to using data (when appropriate) for system development and other resource allocation decisions.

GOALS

1) **Maintain EMS Patient and Trauma Patient registries to monitor evolution of EMS system.**
   Bureau Activities:
   - Continue to provide technical assistance to customers of registries.

- Provide ongoing training to ensure appropriate application of software.
- Continue to increase the ease of submitting data to IDPH.
- Seek support to integrate existing registries.

2) Finalize transition to 100% electronic reporting of data

Bureau Activities:

- Continue to provide information on no-cost methods of submitting data.
- Conduct regional training as needed.

3) The Bureau will continue to contribute Iowa data to national data collection efforts.

Bureau Activities:

- National Trauma Data Bank (NTDB)
- National EMS Information System (NEMSIS)
- National Trauma Registry (spring 2006)

4) Maintain the Bureau of EMS web site.

Bureau Activities:

- Ensure the site has the most accurate and current information available to EMS stakeholders.
- Provide links to other entities that can benefit delivery of EMS care in Iowa.

5) Develop electronic formats for EMS system processes.

- Service application authorization.
- Provider renewal.
- Provider certification
- Resource tracking
- Trauma care facility certification
- Grant processes

EVALUATION

On-going valuation is the essential to assessing the quality and effectiveness of EMS.

GOALS

1) Develop a standardized state-wide evaluation model for Iowa's EMS system.

Bureau Activities:

- Identify a structural, process and outcome measurements.
- Implement a process for corrective action, follow up and re-evaluation.
- Develop and implement a process to disseminate information (reports) from the leadership.

2) Sustain the delivery of the comprehensive model CQI program for local EMS programs.

Bureau Activities:

- Define the roles of medical director, service director, and EMS provider.

- Develop and disseminate evaluation instruments.
- Develop and disseminate EMS report card models.
- Train local leaders to implement and monitor local CQI strategies.

3) Periodically seek a state-wide evaluation by a recognized national organization.

Bureau Activities:

- Obtain funding.
- Identify time for evaluation.
- Disseminate information from the evaluation.

Attachment 44

Pediatric Readiness Project Report

National Pediatric Readiness Project
Ensuring Emergency Care for All Children

State Name: Iowa

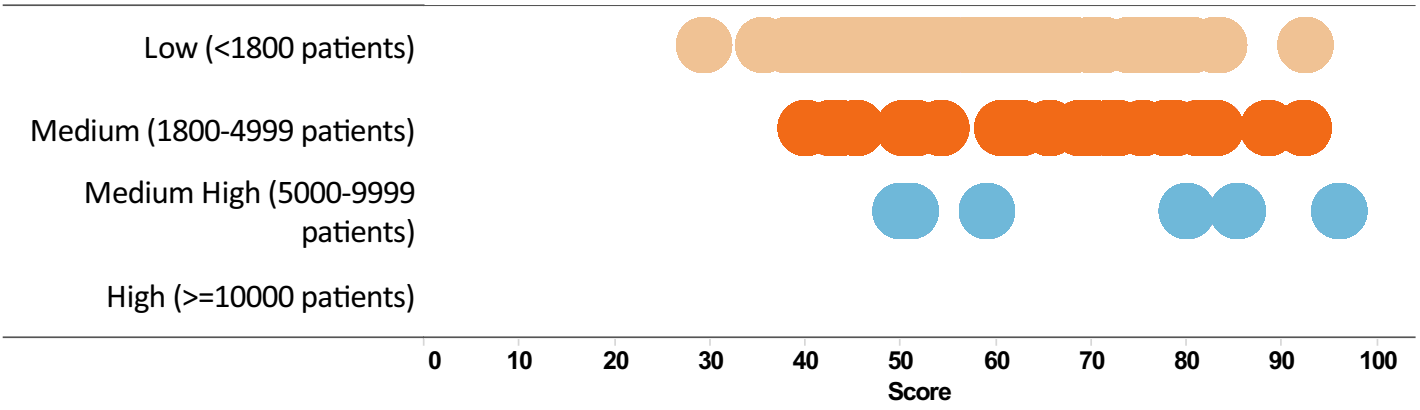
Report Date: 8/29/2013 4:46:14 PM

Number of Hospital Respondents:	116
Number of Hospitals Assessed:	116
Response Rate:	100.0%

STATE SCORE AND COMPARATIVE SCORES:

62	62	69
STATE AVERAGE HOSPITAL SCORE OUT OF 100	STATE MEDIAN HOSPITAL SCORE OUT OF 100	n = 4,143 NATIONAL MEDIAN OF PARTICIPATING HOSPITALS

DISTRIBUTION OF *STATE* SCORES FOR EACH VOLUME TYPE:



BREAKDOWN OF *STATE* SCORES FOR EACH VOLUME TYPE:

Annual Pediatric Volume	# of Hospitals	Avg. Score	Median Score	Min. Score	Max. Score
Low (<1800 patients)	85	59.7	61.2	30	93
Medium (1800-4999 patients)	23	66.3	69.1	40	92
Medium High (5000-9999 patients)	6	70.5	69.8	50	96
High (>=10000 patients)	2				
Grand Total	**116**	**62.3**	**62.3**	**30**	**100**

NOTE: *Blank indicates fewer than 5 hospitals; score can't be shown.*

BREAKDOWN OF *NATIONAL* SCORES FOR EACH VOLUME TYPE:

Annual Pediatric Volume	# of Hospitals	Avg. Score	Median Score	Min. Score	Max. Score
Low (<1800 patients)	1,628	62.0	61.4	22	100
Medium (1800-4999 patients)	1,242	69.8	69.3	27	100
Medium High (5000-9999 patients)	707	73.8	74.8	31	100
High (>=10000 patients)	563	84.3	89.9	35	100
Not Recorded	3				
Grand Total	**4,143**	**69.4**	**69.0**	**22**	**100**

NOTE: *Blank indicates fewer than 5 hospitals; score can't be shown.*

ANALYSIS OF YOUR SCORE:

Below are the average state scores* for each section of the assessment. The scores are based on the weighted assessment items for each section.

** The sum of the sectional scores below may vary slightly from actual overall readiness score above due to rounding.*

Average Section Scores	State Section Scores	National Section Scores
Guidelines for Administration and Coordination (19 pts)	**9.8**	**10.1**
Physicians, Nurses, and Other Health Care Providers Who Staff the ED (10 pts)	**2.6**	**5.3**
Guidelines for QI/PI in the ED (7 pts)	**3.5**	**2.9**
Guidelines for Improving Pediatric Patient Safety in the ED (14 pts)	**9.2**	**10.8**
Guidelines for Policies, Procedures, and Protocols for the ED (17 pts)	**8.9**	**10.5**
Guidelines for Equipment, Supplies, and Medications for the Care of Pediatric Patients in the ED (33 pts)	**28.2**	**29.4**

Guidelines for Administration and Coordination of the ED for the Care of Children

Scored Items

	Yes (N)	% Yes	% National Yes	Difference
Nurse Coordinator	70	60.3%	59.4%	1.0%
Physician Coordinator	50	43.1%	47.5%	-4.4%

Physicians, Nurses, and Other Health Care Providers Who Staff the ED

Scored Items

	Yes (N)	% Yes	% National Yes	Difference
Nurse Competency Evaluations	39	33.6%	66.7%	-33.0%
Physician Competency Evaluations	21	18.1%	38.7%	-20.6%

Guidelines QI/PI

Scored Items

	Yes (N)	% Yes	% National Yes	Difference
Does your ED have a pediatric patient care-review process?	65	56.0%	45.2%	10.9%
The following results are a breakdown of those who said "Yes" to having a pediatric patient care-review process...				
Collection and analysis of pediatric emergency care data	53	81.5%	88.1%	-6.5%
Identification of quality indicators for children	27	41.5%	58.4%	-16.8%
Development of a plan for improvement in pediatric emergency care	47	72.3%	78.9%	-6.6%
Re-evaluation of performance using outcomes-based measures	39	60.0%	73.5%	-13.5%

Guidelines for Improving Pediatric Patient Safety in the ED

Scored Items

	Yes (N)	% Yes	% National Yes	Difference
Weigh in Kilograms	45	38.8%	67.8%	-29.0%
If Weigh in Kilograms, also Record in Kilograms	31	68.9%	75.3%	-6.4%
Temperature, heart rate, and respiratory rate recorded	115	99.1%	98.6%	0.5%
Blood pressure monitoring available based on severity of illness	115	99.1%	98.1%	1.0%
Pulse oximetry monitoring available based on severity of illness	116	100.0%	99.7%	0.3%
Written procedure in place for notification of physicians when abnormal vital signs	55	47.4%	70.2%	-22.8%
Process in place for the use of pre-calculated drug dosing	71	61.2%	79.0%	-17.8%
Process in place that allows for 24/7 access to interpreter services in the ED	110	94.8%	95.5%	-0.7%

Guidelines for Policies, Procedures, and Protocols for the ED

Scored Items

	Yes (N)	% Yes	% National Yes	Difference
Triage policy that specifically addresses ill and injured children	35	30.2%	57.7%	-27.5%
Policy for pediatric patient assessment and reassessment	70	60.3%	73.5%	-13.2%
Policy for immunization assessment and management of the under-immunized child	47	40.5%	51.7%	-11.2%
Policy for child maltreatment	103	88.8%	89.6%	-0.9%
Policy for death of the child in the ED	65	56.0%	58.1%	-2.1%
Policy for reduced-dose radiation for CT and x-ray imaging based on pediatric age or weight	56	48.3%	52.6%	-4.4%
Policy for promoting family-centered care	53	45.7%	59.7%	-14.0%
Hospital disaster plan addresses issues specific to the care of children	41	35.3%	46.9%	-11.5%
Inter-facility transfer guidelines	83	71.6%	70.7%	0.9%

Guidelines for Equipment, Supplies, and Medications for the Care of Pediatric Patients in the ED

Scored Items

	Yes (N)	% Yes	% National Yes	Difference
Is the ED staff trained on the location of all pediatric equipment and medications?	116	100.0%	99.5%	0.5%
Is there a daily method used to verify the proper location and function of pediatric equipment and supplies?	74	63.8%	83.1%	-19.3%
Is a medication chart, length-based tape, medical software, or other system readily available to ensure proper sizing of resuscitation equipment and proper dosing of medications?	116	100.0%	99.5%	0.5%
Neonatal blood pressure cuff	99	85.3%	92.0%	-6.7%
Child blood pressure cuff	116	100.0%	99.9%	0.1%
Defibrillator with pediatric and adult capabilities including pads/paddles	115	99.1%	99.7%	-0.5%
Pulse oximeter with pediatric and adult probes	116	100.0%	99.7%	0.3%
Continuous end-tidal CO2 monitoring device	104	89.7%	81.7%	7.9%
22 gauge catheter-over-the-needle	116	100.0%	99.7%	0.3%
24 gauge catheter-over-the-needle	116	100.0%	99.5%	0.5%
Pediatric intra-osseus needles	115	99.1%	97.6%	1.5%

Guidelines for Equipment, Supplies, and Medications for the Care of Pediatric Patients in the ED *cont.*

Scored Items

	Yes (N)	% Yes	% National Yes	Difference
IV administration sets with calibrated chambers and extension tubing and/or infusion devices with ability to regulate rate and volume of infusate	111	95.7%	95.3%	0.3%
Umbilical vein catheters (3.5F or 5.0F)	69	59.5%	62.4%	-2.9%
Central venous catheters (any two sizes in range, 4F-7F)	40	34.5%	62.6%	-28.2%
Endotracheal tubes: cuffed or uncuffed 2.5 mm	110	94.8%	94.3%	0.5%
Endotracheal tubes: cuffed or uncuffed 3.0 mm	113	97.4%	97.0%	0.4%
Endotracheal tubes: cuffed or uncuffed 3.5 mm	116	100.0%	98.4%	1.6%
Endotracheal tubes: cuffed or uncuffed 4.0 mm	116	100.0%	99.4%	0.6%
Endotracheal tubes: cuffed or uncuffed 4.5 mm	115	99.1%	98.6%	0.6%
Endotracheal tubes: cuffed or uncuffed 5.0 mm	115	99.1%	99.4%	-0.3%
Endotracheal tubes: cuffed or uncuffed 5.5 mm	115	99.1%	98.1%	1.0%
Endotracheal tubes: cuffed or uncuffed 6.0 mm	116	100.0%	99.2%	0.8%
Laryngoscope blades: straight, size 00	85	73.3%	77.5%	-4.2%
Laryngoscope blades: straight, size 0	111	95.7%	94.1%	1.6%
Laryngoscope blades: straight, size 1	114	98.3%	98.2%	0.1%
Laryngoscope blades: straight, size 2	109	94.0%	96.8%	-2.9%

Guidelines for Equipment, Supplies, and Medications for the Care of Pediatric Patients in the ED *cont.*

Scored Items

	Yes (N)	% Yes	% National Yes	Difference
Laryngoscope blades: curved, size 2	107	92.2%	96.5%	-4.2%
Pediatric-sized Magill forceps	81	69.8%	82.5%	-12.6%
Nasopharyngeal airways: infant-sized	95	81.9%	82.9%	-1.0%
Nasopharyngeal airways: child-sized	100	86.2%	87.8%	-1.6%
Oropharyngeal airways: size 0 (50mm)	109	94.0%	92.6%	1.4%
Oropharyngeal airways: size 1 (60mm)	114	98.3%	96.6%	1.7%
Oropharyngeal airways: size 2 (70mm)	112	96.6%	95.7%	0.9%
Oropharyngeal airways: size 3 (80mm)	114	98.3%	96.8%	1.5%
Stylets for pediatric/infant-sized endotracheal tubes	112	96.6%	97.4%	-0.8%
Tracheostomy tubes: size 3.0 mm	66	56.9%	68.2%	-11.3%
Tracheostomy tubes: size 3.5 mm	62	53.4%	68.0%	-14.5%
Tracheostomy tubes: size 4.0 mm	72	62.1%	75.1%	-13.1%
Bag-mask device, self inflating: infant, 450 ml	113	97.4%	96.8%	0.6%
Masks to fit bag-mask device adaptor: neonatal	106	91.4%	92.4%	-1.0%
Masks to fit bag-mask device adaptor: infant	114	98.3%	98.5%	-0.3%
Masks to fit bag-mask device adaptor: child	114	98.3%	99.0%	-0.7%
Clear oxygen masks: standard infant	109	94.0%	93.4%	0.6%
Clear oxygen masks: standard child	116	100.0%	98.1%	1.9%
Non-rebreather masks: infant-sized	88	75.9%	84.1%	-8.2%
Non-rebreather masks: child-sized	102	87.9%	93.8%	-5.8%

Guidelines for Equipment, Supplies, and Medications for the Care of Pediatric Patients in the ED *cont.*

Scored Items

	Yes (N)	% Yes	% National Yes	Difference
Nasal cannulas: infant	105	90.5%	91.0%	-0.5%
Nasal cannulas: child	114	98.3%	95.9%	2.4%
Laryngeal mask airways: size 1	49	42.2%	57.2%	-15.0%
Laryngeal mask airways: size: 1.5	41	35.3%	55.1%	-19.8%
Laryngeal mask airways: size: 2	54	46.6%	60.9%	-14.3%
Laryngeal mask airways: size: 2.5	47	40.5%	58.6%	-18.0%
Laryngeal mask airways: size: 3	61	52.6%	66.4%	-13.8%
Suction catheters: at least one in range 6-8F	115	99.1%	98.5%	0.7%
Suction catheters: at least one in range 10-12F	113	97.4%	99.2%	-1.8%
Supplies/kit for pediatric patients with difficult airways (supraglottic airways of all sizes, needle cricothyrotomy supplies, surgical cricothyrotomy kit)	68	58.6%	75.4%	-16.8%

EMSC
Emergency Medical Services for Children

During 2013-14, 49 states, the District of Columbia, 5 territories, and 3 freely associated states participated in an EMS for Children (EMSC) assessment for two federal, hospital-based performance measures about pediatric inter-facility transfer agreements and guidelines.*

The following is a brief summary of the results of the assessment for **Iowa** with comparison to national percentages.

Iowa had **116** responses from hospitals with Emergency Departments (EDs) and achieved a response rate of **100**. Nationally, over 3,900 EDs responded; a response rate of: 81.3%.

If you would like more information please do not hesitate to contact:

Katrina Altenhofen, MPH, PM
EMS for Children Program Director
Katrina.Altenhofen@idph.iowa.gov

Inter-facility Transfer Agreements:

Percent of hospitals that have inter-facility transfer agreements:

PERCENTAGE: 100

NATIONWIDE PERCENTAGE: 66%

Inter-facility Transfer Guidelines:

		NATIONAL
Does your hospital have inter-facility transfer guidelines?		
Yes, have inter-facility transfer guidelines	100%	69.3%
If yes, which EMSC components are included?		
Process for patient transfer (including obtaining informed consent)	83%	98.8%
Defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center	76%	96.6%
Plan for transfer of patient medical record	82%	98.9%
Plan for transfer of copy of signed transport consent	81%	98.3%
Process for selecting the appropriately staffed transport service to match the patient's acuity level (level of care required by patient, equipment needed in transport, etc.)	71%	91.0%
Process for selecting the appropriate care facility	66%	86.9%
Plan for transfer of personal belongings of the patient	71%	90.6%
Plan for provision of directions and referral institution information to family	64%	82.8%

Percent of hospitals that have inter-facility transfer guidelines with all of the eight EMSC components:

PERCENTAGE: 51%

NATIONWIDE PERCENTAGE: 50%

This report was developed in partnership with the National Emergency Medical Services for Children Data Analysis Resource Center; funded in part by cooperative agreement #U03MC00008.

* The **red boxes** indicate federal reporting for National Performance Measures 76 and 77.

EMSC Emergency Medical Services for Children

During 2013-14, 48 states, the District of Columbia, and 5 territories participated in an EMS for Children (EMSC) assessment for three federal, Emergency Medical Services (EMS)-related performance measures about pediatric medical direction and equipment.*

Iowa had 259 responses from EMS agencies and achieved a response rate of **93.1%**. Nationally, over 8,000 EMS agencies responded; a response rate of: 83.1%.

If you would like more information please do not hesitate to contact:

Katrina Altenhofen, MPH, PM
EMS for Children Program Director

Online Medical Direction:

		NATIONAL
Online Medical Direction Available to Give Medical Advice When Treating a Pediatric Patient:		
BLS Agencies	100%	90.1%
ALS Agencies	100%	89.5%

Offline Medical Direction:

		NATIONAL
Have Written Pediatric Protocols Available:		
BLS Agencies	100%	93.0%
ALS Agencies	100%	98.7%
Protocols Always or Almost Always Available During an EMS Call:		
BLS Agencies	100%	72.0%
ALS Agencies	100%	93.5%

Pediatric Equipment:

		NATIONAL
Percent of Transporting Vehicles that have ALL Nationally Recommended Pediatric Equipment:**		
BLS Vehicles	36.6%	25.3%
ALS Vehicles	36.6%	37.7%
Average % of Nationally Recommended Pediatric Equipment Carried by Transporting Vehicles:		
BLS Vehicles	97%	91.8%
ALS Vehicles	95%	95.5%

Some Interesting Results/Findings from the Data:

-Regardless of funding structure both ALS and BLS levels of EMS have similar missing equipment issues.
-Iowa's average percent of Nationally Recommended Pediatric equipment carried by transporting vehicles is higher than that of the national average

*The **red boxes** indicate federal reporting for National Performance Measures 71, 72, and 73.

Intermediate Life Support (ILS) agencies and vehicles were aggregated with Basic Life Support (BLS).

** "Equipment for Ambulances," a Policy Resource Education Paper, by the American College of Surgeons Committee on Trauma, American College of Emergency Physicians, National Association of EMS Physicians, Pediatric Equipment Guidelines Committee—Emergency Medical Services for Children (EMSC) Partnership for Children Stakeholder Group, and the American Academy of Pediatrics (2009).

This report was developed in partnership with the National Emergency Medical Services for Children Data Analysis Resource Center; funded in part by cooperative agreement #U03MC00008.

Attachment 45

Service Authorization Application

AMBULANCE SERVICE PROGRAM APPLICATION

Before completing this application, read Iowa Code 641--147A and Iowa Administrative Code 641—132(147A) EMS Service Program Authorization. Visit www.idph.state.ia.us/ems for the Iowa EMS laws and rules, protocols, scope of practice and sample policies, procedures and agreements.

INSTRUCTIONS:

This is the initial application for EMS agencies that are seeking authorization to provide ambulance service in Iowa. This application shall be submitted to the EMS Regional Coordinator assigned to the intended primary service area at least 30-days prior to the anticipated authorization date.

Once this completed application and all required documentation is received, the EMS Regional Coordinator will contact you to schedule the onsite inspection. A service login name and password will be issued for EMS System Registry, the official online application. Be prepared to register staff including EMS certification, CPR and driver's license expiration dates and emergency driving and communications training date.

The application will be approved when the Iowa Department of Public Health is satisfied that the program proposed by the application will be operated in compliance with Iowa Code 641--147A and the enabling administrative rules.

EMS REGIONAL COORDINATORS – ASSIGNED COUNTIES:

Anita Bailey
PO Box 183
Milford, IA 51351
Anita.Bailey@idph.iowa.gov
Office: 515.240.4943
Buena Vista, Calhoun, Carroll, Cherokee, Clay, Crawford, Dickinson, Emmet, Greene, Hamilton, Hancock, Humboldt, Ida, Kossuth, Lyon, Monona, O'Brien, Osceola, Palo Alto, Plymouth, Pocahontas, Sac, Sioux, Webster, Winnebago, Woodbury, Wright

Evelyn Wolfe
PO Box 91
Solon, IA 52333
Evelyn.Wolfe@idph.iowa.gov
Office: 319.331.1354
Appanoose, Cedar, Clinton, Davis, Des Moines, Henry, Iowa, Jackson, Jasper, Jefferson, Johnson, Jones, Keokuk, Lee, Louisa, Mahaska, Marion, Monroe, Muscatine, Poweshiek, Scott, Van Buren, Wapello, Washington, Wayne

Merrill Meese
PO Box 41
Alexander, IA 50420
Merrill.Meese@idph.iowa.gov
Office: 515.344.2793
Allamakee, Benton, Black Hawk, Butler, Bremer, Buchanan, Cerro Gordo, Chickasaw, Clayton, Delaware, Dubuque, Fayette, Floyd, Franklin, Grundy, Hardin, Howard, Linn, Mitchell, Tama, Winneshiek, Worth

Ellen McCardle-Woods
PO Box 316
Colo, IA 50056
Ellen.McCardle-Woods@idph.iowa.gov
Office: 515.240.5138
Adair, Adams, Audubon, Boone, Cass, Clarke, Dallas, Decatur, Fremont, Guthrie, Harrison, Lucas, Madison, Marshall, Mills, Montgomery, Page, Polk, Pottawattamie, Ringgold, Shelby, Story, Taylor, Union, Warren

THIS SPACE FOR BUREAU OF EMS USE ONLY.		
Service Program Number:	Date Application Received:	OK or Reason Returned:
Onsite Inspection Date:	Entered into System Registry:	Date Certificate Issued:

AMBULANCE SERVICE APPLICATION

SERVICE PROGRAM NAME:	
PHYSICAL LOCATION: ADDRESS-CITY-STATE-ZIP CODE-COUNTY:	
MAILING ADDRESS: ADDRESS-CITY-STATE-ZIP CODE:	
SERVICE TYPE:	TEMPORARY:
LEVEL:	STAFFING TYPE:
CRITICAL CARE TRANSPORT TYPE:	
BASE OF OPERATION:	PERSONNEL TYPE:
RESPONSE TYPE:	PHARMACY TYPE:
REGULAR MEETING SCHEDULE:	
SERVICE DIRECTOR CONTACT INFORMATON:	
First Name:	Last Name:
Phone:	Email:
PREFERRED SERVICE CONTACT: **(IF DIFFERENT THAN SERVICE DIRECTOR INFORMATION)**	
First Name:	Last Name:
Phone:	Email:
DISPATCH CENTER INFORMATION:	
Name of Dispatch Center:	

Contact First Name:	Last Name:
Nonemergency Phone:	Email:
Call System Type:	
Telecommunicators EMD Trained:	EMD Provided:
SERVICE OWNERSHIP:	
Ownership Type:	
Responsible Party Contact Information:	
First Name:	Last Name:
Phone:	Email:
Vehicle Insurance Company Name:	
Medial Liability Insurance Company Name:	
Workers Compensation Insurance Company Name:	
MEDICAL DIRECTOR INFORMATION:	
First Name:	Last Name:
	Iowa License Number:
Phone:	Email:
Has this physician attended the Iowa EMS Service Director Workshop?	
Location:	Year (approximately):
PRIMARY ON-LINE MEDICAL DIRECTION HOSPITAL:	
Hospital Name:	City:
PHARMACY INFORMATION: **(IF PHARMACY OR COMBINATION OPTION IS SELECTED)**	
Pharmacy Name:	
Street Address:	
City-State-Zip code:	
Phone:	Email:
Pharmacist Name:	License number:
DISASTER QUESTIONS:	

1. Is the service willing to respond to a disaster in Iowa?	
2. Is the service willing to respond to a disaster that occurred outside of Iowa?	

OPERATIONAL QUESTIONS:	
1. Which of the following does your service primarily respond to?	
2. Does the service ensure that personnel duties are consistent with their level of certification and the service program's level of authorization?	
3. Does the service maintain personnel files that include:	
a. Documentation of current certification/driver's license and CPR course completion?	
b. Current course completions/certifications/endorsements as required by the medical director?	
c. RN/PA exception forms and verification that the RN and/or PA's have completed the appropriate EMS level continuing education as required by the medical director?	
4. Our members/staff are: ***A volunteer is someone that receives no or nominal compensation not based upon the value of the services performed.***	
5. How many non-EMS certified, licensed drivers do you have?	
6. Does the service carry equipment and supplies in quantities as determined by the medical director and appropriate to the level of care and as established by protocol?	
7. How many ambulances do you have?	
8. How many of the ambulances are staffed (scheduled) 24/7?	
9. How many total calls for service (include cancelled, standby, no patient found, treat and release and other similar types) does your service have per year?	
10. Does your ambulance service program maintain a telecommunications system between the emergency medical care provider and the responding ambulance services and other appropriate entities?	
11. Is the telecommunications equipment capable of transmitting and receiving clear and understandable voice communication to and from the service program's communication base and all points within the service program's primary service area?	

PREVENTATIVE MAINTENANCE QUESTIONS:	
1. Vehicles are fully equipped and maintained in safe operating condition?	
2. All ambulances are housed in a garage or other facility that is heated or each ambulance has permanently installed auxiliary heating units to sufficiently heat the engine and patient compartment?	
3. An unobstructed exit to the street is maintained?	
4. Is the garage or other facility adequately heated or does each ambulance have permanently installed auxiliary heating units to sufficiently heat the engine and patient compartment?	
5. The garage or other facility is maintained in a clean, safe condition, free of debris or other hazards?	
6. Are the exterior and interior of the vehicles kept clean?	
7. When a patient with a communicable disease has been transported or treated, is the interior of the ambulance and any equipment or non-disposable supplies coming in contact with the patient thoroughly disinfected?	
8. Is all equipment stored in a patient compartment secured so that, in the event of a sudden stop or movement of the vehicle, the patient and service program personnel are not injured by moving equipment?	
9. Is all airway, electrical and mechanical equipment kept clean and in proper operating condition?	
10. Are the vehicles compartments and other medical supplies stored therein kept in a clean and sanitary condition?	
11. Is all airway and oxygen equipment or other supplies or equipment coming in direct patient contact, of a single-use disposable type or cleaned/disinfected prior to reuse?	
12. Are freshly laundered blankets and linen, or disposable linens used on cots and pillows, and are they changed after each use?	
13. Is there proper storage provided for clean linen?	
14. Are soiled supplies appropriately disposed according to current biohazard practices?	

OPERATIONAL REQUIREMENTS:

THE FOLLOWING ITEMS MUST BE SUBMITTED WITH THIS APPLICATION
IF THEY APPLY TO YOUR ANTICIPATED LEVEL OF AUTHORIZATION:

1. Patient care report

2. Physician approved protocol authorization and changes page and drug list. (Do not send the entire set of protocols)
3. Critical care transport protocols
4. Map of the geographic service area
5. Continuous Quality Improvement Policy that includes designee appointments and addresses staff orientation and credentialing, defines procedures for written PCR audits, skills competency, minimum CEH, follow-up & resolution and measurable outcomes
6. Vehicle, equipment and supply checklists
7. Emergency driving and communications policy
8. Pharmacy agreement and policies and procedures
9. Contingency plan
10. Transportation agreement
11. Identify the software program that will be utilized for electronic data submission

At the initial onsite inspection, the EMS Regional Coordinator will inspect paper or electronic files that verify the following training and orientation according to the service level of authorization:

1. Records for all staff:
    a. CPR and current course completions/certifications/endorsements as may be required by the medical director
    b. Initial orientation to the service
    c. Emergency driving and communication training
    d. Driver's license
2. In addition to the items in #1, records for EMS certified individuals:
    a. Protocol training, including administration of over-the-counter and/or prescription medications approved by the physician medical director
    b. Scope of practice training
    c. Pharmacy policies and procedures training
3. In addition to the items in #1 & #2, PA and RN Exception forms and verification that the PA and RN personnel have completed equivalency training, service orientation and the appropriate EMS level continuing education.

STATEMENT OF AFFIRMATION:

I hereby affirm and declare that I have read 641—132 (147A) and that the service program named in this application will comply with all applicable requirements set forth. I further affirm and declare that the answers and statements in this application are true

and correct. I understand that any falsification of this information may result in denial, citation and warning, suspension, revocation or probation of the service program's authorization. I understand that service programs may advertise or otherwise hold itself out to the public as an authorized service program to the level of care maintained 24/7.

	TYPE OR PRINT FIRST NAME	SIGNATURE	DATE
Service Owner or Authorized Representative			
Medical Director			
Service Director			

SATELLITES: Provide the following information for each satellite service.

SATELLITE NAME:	
PHYSICAL LOCATION: ADDRESS-CITY-STATE-ZIP CODE-COUNTY:	
MAILING ADDRESS: ADDRESS-CITY-STATE-ZIP CODE:	
SERVICE TYPE:	TEMPORARY:
LEVEL:	STAFFING TYPE:
BASE OF OPERATION:	PERSONNEL TYPE:
SATELLITE CONTACT INFORMATON:	
First Name:	Last Name:
Phone:	Email:
SERVICE OWNERSHIP: If different than above	
Ownership Type:	
Responsible Party Contact Information:	
First Name:	Last Name:

Phone:	Email:
Vehicle Insurance Company Name:	
Medial Liability Insurance Company Name:	
Workers Compensation Insurance Company Name:	

SATELLITE NAME:	
PHYSICAL LOCATION: ADDRESS-CITY-STATE-ZIP CODE-COUNTY:	
MAILING ADDRESS: ADDRESS-CITY-STATE-ZIP CODE:	
SERVICE TYPE:	TEMPORARY:
LEVEL:	STAFFING TYPE:
BASE OF OPERATION:	PERSONNEL TYPE:
SATELLITE CONTACT INFORMATON:	
First Name:	Last Name:
Phone:	Email:

SATELLITE NAME:	
PHYSICAL LOCATION: ADDRESS-CITY-STATE-ZIP CODE-COUNTY:	
MAILING ADDRESS: ADDRESS-CITY-STATE-ZIP CODE:	
SERVICE TYPE:	TEMPORARY:
LEVEL:	STAFFING TYPE:
BASE OF OPERATION:	PERSONNEL TYPE:

SATELLITE CONTACT INFORMATON:	
First Name:	Last Name:
Phone:	Email:

Attachment 46

Service Contingency Plan

EMS CONTINGENCY PLAN

SECTION 1:
PARTIES TO THIS AGREEMENT

The following agencies enter this agreement to ensure all components of the EMS system are efficiently and effectively utilized to ensure appropriate transportation of patients in the given system area.

AMBULANCE SERVICES				
Service Name	City	Representative Name	Signature	Date
AMBULANCE SERVICES WITH TRANSPORT AGREEMENT				
Service Name	City	Representative Name	Signature	Date
COMMUNICATION CENTER				
Name	City	Representative Name	Signature	Date

SECTION 2:
PURPOSE OF AGREEMENT

Iowa law requires an ambulance service program to maintain an EMS contingency plan that will be put into operation when coverage pursuant to the 24/7 rule is not possible due to unforseen circumstances. This agreement will allow participating ambulance services to ensure patient transportation is available, define the responsibilities of each program, and provide risk management.

An EMS contingency plan is defined as “a transport agreement or dispatching policy between two or more EMS service programs that addresses how and under what circumstances patient transportation will be provided in a given service area.” 641--

Iowa Administrative Code 132.1(147A).

A transport agreement is defined as "a written agreement between two or more service programs that specifies the duties and responsibilities of the agreeing parties to ensure appropriate transportation of patients in a given service area." 641 Iowa Administrative Code 132.1 (147A).

For purposes of this agreement, the "requesting service program" is the ambulance service program which requests assistance pursuant to this agreement and the "responding service program" is the ambulance service program which is requested to respond pursuant to this agreement. Parties to the agreement may function as either requesting service programs or responding service programs depending on the circumstances of the response.

The parties have entered into this agreement to effectuate these requirements.

SECTION 3:
DUTIES AND RESPONSIBILITIES

A. Authority to Request and Provide Assistance. The senior EMT of a service program or his or her designee shall have the authority to make a request for assistance or to provide assistance under this agreement. All requests for assistance shall be placed through the local communications center.

B. When Assistance May Be Requested. Assistance pursuant to this agreement may be requested when an unforeseen incident or event occurs, including but not limited to equipment or vehicle malfunction, failure, or unavailability, or staff illness or injury.

C. Response to Request. The responding service program shall determine the availability of staff and vehicles and either respond or notify the communications center to dispatch another program.

D. Personnel, Vehicles, and Equipment. The requesting service program shall include in the request for assistance the specific personnel, vehicle, and equipment needs and the location of need. The final decision on the number and nature of personnel, equipment and vehicles to be sent shall be solely that of the responding service program.

E. Authority at the Scene. The responding service program shall report to the senior EMT of the requesting service program. The senior EMT of the requesting service program shall have the authority to issue reasonable orders and directives unless he or she relinquishes this authority to another EMS provider of equal or higher certification

on either service program. The purpose of this section is to maintain order at the scene and shall not be construed to establish an employee/employer relationship.

F. Reporting and Recordkeeping. The requesting service program shall maintain records regarding the frequency of the use of this agreement and provide them to the Bureau of Emergency and Trauma Services upon request. Each service program shall maintain individual patient care reports.

G. Compensation/Reimbursement. Insert applicable compensation and reimbursement provisions.

H. Insurance. Each party to the agreement shall procure and maintain such insurance as is required by applicable federal and state law and as may be appropriate and reasonable to cover its staff, equipment, vehicles, and property, including but not limited to liability insurance, workers compensation, unemployment insurance, automobile liability, and property damage.

I. Liability. EMS providers responding to a requesting service program pursuant to this agreement shall be considered as acting under the lawful order of the responding service program of which they are a member. Each service program shall bear the liability and cost of damage to its personnel, vehicles, and equipment. Each service program shall be responsible for defending claims made against it or its staff arising from participation in this agreement. The responding service program and staff shall be absolved from liability in connection with all acts undertaken pursuant to this agreement, provided that the final decision is made with reasonable diligence.

J. Status and Responsibilities of Parties. Nothing in this agreement shall be construed as creating or constituting the relationship of partnership or joint venture between the parties hereto. Each party shall be deemed to be an independent contractor. No party, unless otherwise specifically provided for herein, has the authority to enter into any contract or create an obligation or liability on behalf of, in the name of, or biding upon another to this agreement.

Each of the parties shall be responsible for ensuring that all persons acting on behalf of the party are properly licensed, certified, or accredited as required by applicable federal and state law.

Each of the parties to the agreement shall be responsible for withholding taxes, social security, unemployment, worker's compensation, and other taxes for its employees and shall hold all other parties harmless for the same.

K. Termination. Any party to this agreement may withdraw from the agreement by

providing thirty days written notice by certified mail to the other parties and to their EMS Regional Coordinator. Staff contact information is available at www.idph.state.ia.us/ems >> Bureau >> Bureau Staff. If a party withdraws from the agreement, the agreement shall remain in effect as to all remaining parties so long as two or more service programs are parties to the agreement.

L. Duration of Agreement: The agreement shall be in effect upon signature of two or more service programs. The agreement shall be in effect for three years from the date of execution unless terminated earlier in accordance with the termination section of this agreement. The agreement may be extended for an additional three year term upon mutual agreement of the parties in writing at least thirty days before the termination date.

Attachment 47

EMS System Response Agreement

EMS SYSTEM RESPONSE AGREEMENT

SECTION 1:
PARTIES TO THIS AGREEMENT

The following agencies enter this agreement to ensure all components of the EMS system are efficiently and effectively utilized to ensure appropriate transportation of patients in the given system area.

DESCRIBE THE GEOGRAPHIC AREA:

AMBULANCE SERVICES				
Service Name	City	Representative Name	Signature	Date
AMBULANCE SERVICES WITH TRANSPORT AGREEMENT				
Service Name	City	Representative Name	Signature	Date
NONTRANSPORT SERVICES				
Service Name	City	Representative Name	Signature	Date
COMMUNICATION CENTER				
Name	City	Representative Name	Signature	Date

SECTION 2:
PURPOSE OF AGREEMENT

An EMS system is developed to provide an organized response to emergency medical service incidents within a given service area. Participants of this agreement intend to provide systematic response to incidents within their jurisdictions. This agreement will allow participating EMS services to ensure patient transportation is available, will define the responsibilities of each program, and provide risk management.

Iowa EMS Service Levels and Requirements:

A. 24/7 Ambulance Service. Iowa law requires an ambulance service to provide coverage with minimum staffing 24/7. Additionally, ambulance services must maintain an EMS contingency plan that will be put into operation when coverage pursuant to the 24/7 rule is not possible due to unforeseen circumstances.

B. Ambulance Service with Transport Agreement (AMB/TA). Iowa law allows an ambulance service that is unable to fulfill the 24/7 staffing requirement to request approval to provide *"nontransport coverage in addition to or in lieu of ambulance authorization"*. Programs seeking such approval must maintain a written transport agreement which specifies how and when patients will be transported.

C. Nontransport Service (NT). Iowa law requires all NT services to maintain a written transport agreement that specifies the duties and responsibilities of the agreeing parties to ensure appropriate transportation of patients in a given service area.

The parties have entered into this agreement to effectuate these requirements.

SECTION 2:
DISPATCH POLICY FOR THE TRANSPORTATION AGREEMENTS

A. Ambulance Dispatch. The communications center will dispatch the closest appropriate ambulance service immediately upon request. If no response within _____minutes, a second page will occur. If no response within _____minutes, the next closet ambulance service will be paged. This sequence shall continue until an adequate response has been initiated.

B: Authorization Level: Ambulance/TA. The following ambulance services agree to provide transportation and the communications center will dispatch as described below.
EXAMPLES: simultaneous dispatch weekdays from 6:00 a.m. – 6:00 p.m. OR simultaneous dispatch 24/7 OR simultaneous dispatch 24/7 and the AMB/TA will contact the incoming ambulance to disregard if local staffing is adequate, etc.

Ambulance/TA Name	Ambulance Service Name	Describe the Dispatch Policy

C. Authorization Level: Nontransport. The communications center agrees to simultaneously dispatch the ambulance service with the nontransport service 24/7.

Nontransport Service Name	Ambulance Service Name

D. System Response Continuous Quality Improvement. The EMS system response effectiveness will be routinely monitored. As a minimum, response times for all agencies within the system, number of and reason for self-dispatches and delayed responses shall be monitored. A process to review and resolve difficult situations and improve the system response shall be implemented when necessary.

SECTION 3:
CONTINGENCY PLANS FOR THE AMBULANCE SERVICES

For purposes of this agreement, the "requesting service program" is the ambulance service program which requests assistance pursuant to this agreement and the "responding service program" is the ambulance service program which is requested to respond pursuant to this agreement. Parties to the agreement may function as either requesting service programs or responding service programs depending on the circumstances of the response.

A. Authority to Request and Provide Assistance. The senior EMT of a service program or his or her designee shall have the authority to make a request for assistance or to provide assistance under this agreement. All requests for assistance shall be placed through the local communications center.

B. When Assistance May Be Requested. Assistance pursuant to this agreement may be requested when an unforeseen incident or event occurs, including but not limited to equipment or vehicle malfunction, failure, or unavailability or staff illness or injury.

C. Response to Request. The responding service program shall determine the availability of staff and vehicles and either respond or notify the communications center to dispatch another program.

D. Personnel, Vehicles, and Equipment. The requesting service program shall include in the request for assistance the specific personnel, vehicle, and equipment needs and the location of need. The final decision on the number and nature of personnel, equipment and vehicles to be sent shall be solely that of the responding service program.

E. Authority at the Scene. The responding service program shall report to the senior EMT of the requesting service program. The senior EMT of the requesting service program shall have the authority to issue reasonable orders and directives unless he or she relinquishes this authority to another EMS provider of equal or higher certification on either service program. The purpose of this section is to maintain order at the scene and shall not be construed to establish an employee/employer relationship.

F. Reporting and Recordkeeping. The requesting service program shall maintain records regarding the frequency of the use of this agreement and provide them to the Bureau of Emergency and Trauma Services upon request. Each service program shall maintain

individual patient care reports.

G. Personnel Credentialing. Each of the parties shall be responsible for ensuring that all persons acting on behalf of the party are properly licensed, certified, or accredited as required by applicable federal and state law.

H. Tax Liability: Each of the parties to the agreement shall be responsible for withholding taxes, social security, unemployment, worker's compensation, and other taxes for its employees and shall hold all other parties harmless for the same.

I. Compensation/Reimbursement. Insert applicable compensation and reimbursement provisions.

J. Insurance. Each party to the agreement shall procure and maintain such insurance as is required by applicable federal and state law and as may be appropriate and reasonable to cover its staff, equipment, vehicles and property, including but not limited to liability insurance, workers compensation, unemployment insurance, automobile liability and property damage.

K. Liability. Each party to the agreement shall bear the liability and cost of damage to its personnel, vehicles, and equipment. Each party to the agreement shall be responsible for defending claims made against it or its staff arising from participation in this agreement.

L. Status and Responsibilities of Parties. Nothing in this agreement shall be construed as creating or constituting the relationship of partnership or joint venture between the parties hereto. Each party shall be deemed to be an independent contractor. No party, unless otherwise specifically provided for herein, has the authority to enter into any contract or create an obligation or liability on behalf of, in the name of, or biding upon another to this agreement.

M. Termination. Any party to this agreement may terminate the agreement by providing thirty days written notice by certified mail to the other parties and to their Bureau of Emergency and Trauma Services Regional Coordinator. Staff contact information is available at www.idph.state.ia.us/ems >> Bureau >> Bureau Staff. If a party withdraws from the agreement, the agreement shall remain in effect as to all remaining parties so long as two or more service programs are parties to the agreement

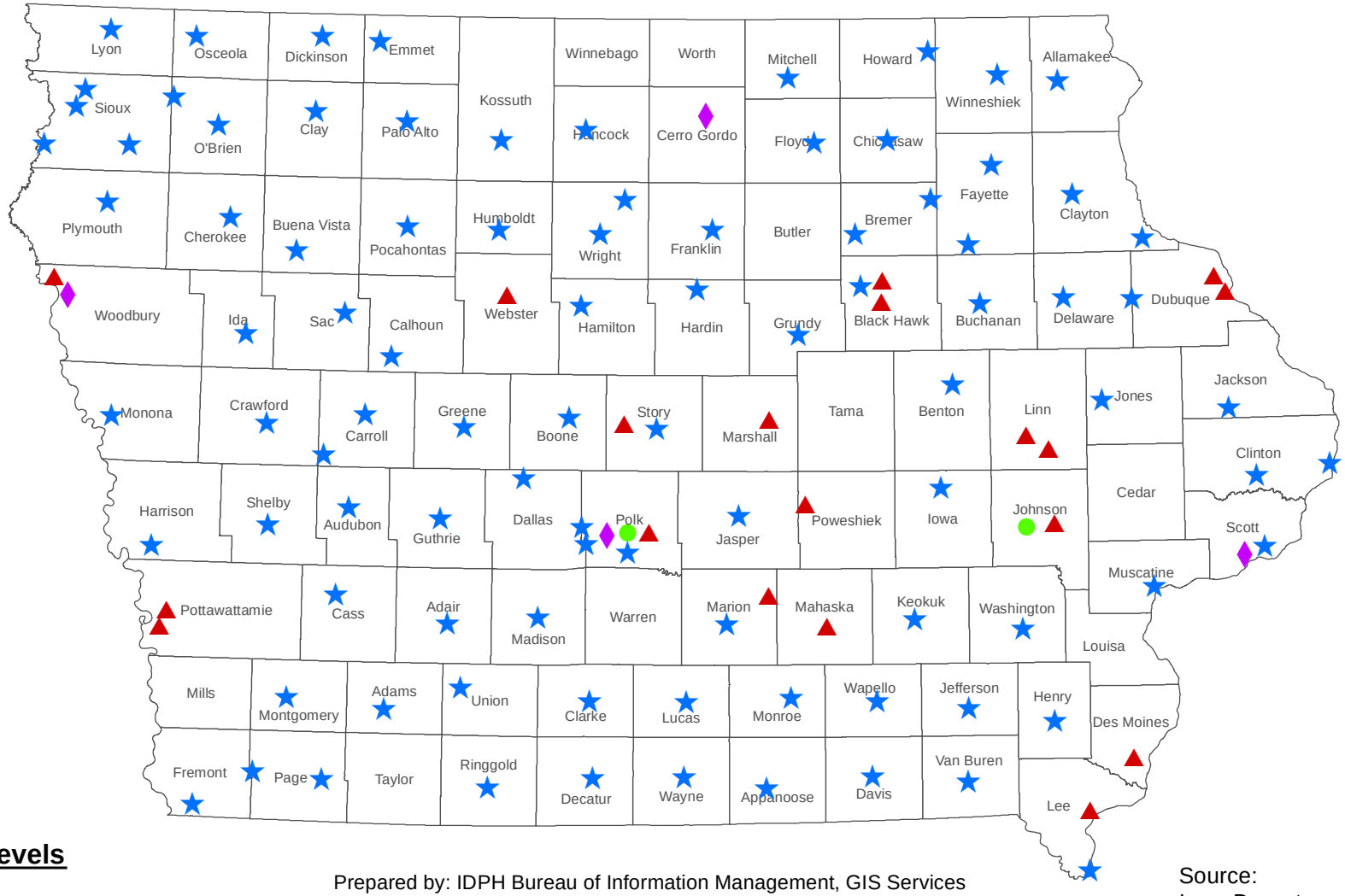
N. Duration of Agreement. The agreement shall be in effect upon signature of the service program participants. The agreement shall be in effect for three years from the date of execution unless terminated earlier in accordance with the termination section of this agreement. The agreement may be extended for additional three year terms upon mutual agreement of all parties in writing at least thirty days before the termination date.

Attachment 48

Trauma Map

Iowa Department of Public Health
Bureau of EMS

Iowa's Trauma Care Facilities
March 2014



Certification Levels

- Resource (Level I)
- Regional (Level II)
- Area (Level III)
- Community (Level IV)

Prepared by: IDPH Bureau of Information Management, GIS Services
3/13/2014

Source:
Iowa Department of Public Health
Bureau of EMS
321 E 12th Street
Lucas State Office Building
Des Moines, IA 50319
1-800-SAVE-EMS
www.idph.state.ia.us/EMS

Attachment 49

IDPH Communication Plan

Iowa Department of Public Health Communication Plan

February 2015

Iowa Department of Public Health Communication Plan

TABLE OF CONTENTS

INTRODUCTION

This document is a guide for having a united and consistent voice for the Iowa Department of Public Health. The intention of these guidelines is not to introduce an inflexible approach to media relations and departmental communications, but to provide a useful tool for improving the overall dissemination of vital public health information. A structured approach to public message development and media interviews will ensure the IDPH mission to promote and protect the health of Iowans is met more effectively.

This document will review IDPH's policies and protocols regarding press release development, responding to the media, working with reporters, tracking media interaction and the use of graphic design. Issues associated with marketing and social media will also be reviewed.

In addition, internal staff communication issues will be addressed. This document will outline effective strategies for communicating to and with fellow IDPH employees.

Media

Press Release Development and Dissemination

Press releases are written documents prepared in advance by IDPH for release to the media. They briefly summarize important health information for the public or highlight an upcoming health-related event or program sponsored by IDPH. Press releases are written and prepared by the Communications Director and emailed to the IDPH News LISTSERV, which includes members of the media (radio, television and print), other state agencies, as well as members of the public who choose to subscribe to the list.

The process for creating and disseminating an IDPH press release is as follows:

1. The process should ideally begin two weeks prior to the anticipated release date. Urgent or risk communication messages are the exception to this guideline.
2. Program or individual contacts Communication Director with press release idea OR Communications Director suggests press release to program/individual.
3. Program or individual provides background information, bullet points, and web sites related to press release topic to the Communications Director.
4. Communications Director drafts the release for approval by the Subject Matter Expert (SME).
5. Upon approval by SME, press release is submitted for approval to Bureau Chief.
6. Upon approval by Bureau Chief, press release is submitted to Division Director for approval.
7. Upon approval by Division Director, press release is submitted to IDPH Director for approval if release is of a sensitive nature.
8. Upon appropriate approvals, press release is emailed to LPHA agencies and the IDPH News LISTSERV.

It is imperative that this process be followed precisely in order to maintain a consistent relationship with the media. The Communications Director is tasked with sending out news releases and maintaining the current media contact list.

Media Contact Policy

Occasionally, a reporter will contact an IDPH employee directly and want an immediate interview. When this happens during regular business hours, after hours, or during a public health emergency advise the reporter, per IDPH policy, that they must contact the IDPH Communications Director. By applying this standard, you ensure that you will not go into an interview without being fully prepared. The best response is rarely the quickest one, so preparing your answers in advance is imperative.

A media contact is defined as any of the following:

- Television interview or appearance
- Radio interview
- Newspaper interview
- Blogger or other web-writer interview (many newspaper, television and radio interviews now also result in web publication)
- Other Media Contact (e.g., phone call, phone interview, personal conversation or discussion)

Sometimes reporters choose to deliberately circumvent the established policy, especially if the information is a:

- Crisis situation
- Time-urgent
- Emergency
- Hot political topic or other controversial issue

All media inquiries must be routed through the Communications Director. Having a structured procedure adds comfort and security both during an emergency situation and regular duties. It is intended to protect the department and its representatives while assuring the IDPH message reaches the public.

- If contacted by the Communications Director to respond to a media inquiry, the subject line of the email will read 'MEDIA INQUIRY' (followed by subject matter of request).

- The email will include the name of the reporter/media outlet/phone number, as well as any background on what the reporter is looking for.
- If you have questions or are uncomfortable responding to the reporter, let the Communications Director know right away.
- Please also advise the Communications Director if you will not be able to contact the reporter within the time frame given (always within at least two hours).

All media inquiries routed through the Communications Director must be responded to as soon as possible, but always within two hours.

The *Media, Legislative and Public Communications Policy* may be found on the IDPH Intranet under the Policies tab.

Tracking Media Inquiries

Keeping accurate records of all media contacts is essential for maintaining and improving IDPH's media relation's efforts. Accurate records are enhanced when all media inquiries are routed through the Communications Director.

If an employee conducts an interview that they perceive may result in controversial or negative media coverage, employees shall complete the *Media, Legislative and Public Communications* form found on the All Staff Intranet page under Policies: Administration tab within 24 hours of contact. The completed form shall be e-mailed to the "IDPH LegisMedia" distribution group in Outlook. **Routine interviews coordinated through the Communications Director do not require completion of the IDPH Contact Form**.

Each day, the Communications Director will prepare a synopsis of media contacts for the day including name of media outlet, reporter's name, subject matter discussed, and IDPH employee who was interviewed. This synopsis is sent to key personnel within IDPH and the Governor's office.

Marketing

Marketing is the process of developing, producing and publishing targeted advertisements or advertisement campaigns specific to IDPH through a variety of media. It can be developed in-house or under contract by an approved vendor or through the RFP process. Marketing includes but is not limited to broadcast, such as television or radio advertisements; print, including but not limited to posters, flyers, banners, brochures, and newsletter and newspaper advertisements; and web-based advertising, such as web banners.

IDPH currently holds sole source contracts with Learfield Communications for radio advertising and Clear Channel Outdoor for billboards. Additional advertising outlets may be available that do not require an RFP. Ask the Communications Director for information.

ALL MATERIALS developed by IDPH will take into consideration cultural sensitivities and needs of the target audience of those materials. This includes but is not limited to language, ethnicity, race, age, gender or gender identity, sexual orientation, religion, low literacy, homebound and visual, hearing other physical impairment.

It is important that any public campaign include review prior to release for inclusiveness of audiences and for grammar/language. It is recommended that all campaigns designed by IDPH programs for use externally be reviewed by the Communications Director (or their designee) and the Health Promotions Designer prior to final approval. The turnaround time from receipt of the item for review and approval and/or suggestions and comments shall be no less than two business days. Partner campaigns funded by IDPH do not need this level of review.

Written public documents, such as brochures, reports, etc. should undergo document review prior to publication to ensure a professional and consistent departmental appearance. Please forward all written material to the Communications Director for document review. Review of written materials shall be completed within two business days.

Use of Graphic Resources in Communications

The process for developing original in-house graphic arts is as follows:

1. Using the Employee Resources tab on the IDPH Intranet, access the Health Promotions Designer Services Requests document.
2. Complete this document to begin the design process.
3. The Health Promotions Designer will then determine if a face-to-face meeting is necessary to learn more about the project.

Using the IDPH logo

There are standards of use and acceptable/unacceptable ways in which to use the IDPH logo. A variety of IDPH logos are available on the S:drive in the Resources folder. This folder also contains logo standards of use and examples of acceptable and unacceptable ways in which to use it.

Finding graphics on the Internet

It is illegal to steal anything from a Web site you don't have express permission to use. If you have need for a graphic or image, please contact the Health Promotions Designer, who has access to images which are free and legal for use by IDPH. Consulting with the Health Promotions Designer will also ensure the image selected is appropriate for its intended use (PowerPoint, document, Internet, etc.), the quality is acceptable, and the cultural sensitivities and needs of the target audience of those materials are met.

IDPH Marketing Advisory Committee (Formerly Social Marketing Committee)

The IDPH Marketing Advisory Committee can share best practices for marketing ideas and techniques, as well as marketing lessons learned.

- The IDPH Marketing Advisory Committee shall consist of 12 members, representing no more than two individuals from each of the five IDPH divisions, as well as the Communications Director and the IDPH Health Promotions Designer.
- Committee members shall be assigned by their respective Division Directors.

- The Committee shall meet every other month; six times per year.
- Each Committee member is tasked with gathering information about upcoming or completed campaigns to share with the group as a whole.
- The IDPH Communications Director shall serve as Committee Chairperson.
- The Committee shall elect a Secretary to a one-year term. The Secretary shall record all updates and discussions and post a summary to the All Staff page, as well as provide an emailed copy to each member of the Committee. Members are encouraged to share these meeting minutes widely among their bureaus and division.

Social Media

IDPH currently has five departmental social media channels: Facebook, Twitter, YouTube, LinkedIn and Pinterest.

The Communications Director shall maintain the departmental social media accounts. This shall include:

- At least once daily (per work week) posts to Twitter
- At least four weekly (per work week) posts to Facebook
- At least three pins to Pinterest boards (per work week)
- Posts to LinkedIn as positions/internships are announced.
- Posts to YouTube as requested by programs/bureaus.

IDPH Social Media Profiles

Staff wishing to establish professional IDPH social media accounts for use during work hours must do so following the Facebook Professional Profile Guide found on the IDPH Intranet under the Policies: Administration tab.

Establishing and Maintaining Social Media Pages

Programs interested in creating a Facebook page shall follow the procedures outlined in the Social Media Policy found on the IDPH Intranet under the Policies: Administration tab.

If approved, a Facebook page will undergo a one year trial period. After that period:

- Programmatic or bureau-level social media accounts with more than100 followers may continue to operate under IDPH policy guidelines. Accounts with fewer than 100 followers shall close the account or transition to a 'Group' page (such as a special interest group; i.e., EMS providers)

- Social media accounts which have been created by outside vendors must be maintained and updated per the departmental standards outlined above. Failure to do so shall result in retirement of the page/account.

All programs are encouraged to provide information to the Communication Director for posts to the IDPH Departmental social media accounts.

Internal Communications

Internal communications include communications between IDPH staff. The following guidelines will help enhance internal communications by utilizing existing platforms and by establishing general guidelines.

All Staff Intranet Page

The All Staff Intranet page is a resource available to all IDPH staff. The page includes announcements or information under the headings of Department Announcements, Personnel, Employee Announcements and HEART.

Department Announcements include IDPH news releases, state government news, and IDPH events.

Personnel information includes job postings, benefits information and payroll announcements.

HEART (Health Employees Activities and Recognition Team) information includes recognition events, fundraisers information and appreciation events.

The All Staff page (https://intranet.idph.state.ia.us/AllStaff.aspx) is an excellent source of department-wide information and announcements. Any employee may submit items for the All Staff page, following the guidelines set forth in the All Staff Intranet Page Use policy, which may be found under the Policies: Administration tab on the All Staff page. The Intranet Page Use Posting Form, by which announcements may be submitted, can also be found under the Policies: Administration tab.

Out of Office Guidelines

To help avoid communication gaps both externally and internally, it is important to utilize resources available to you when you will out of the office for work, vacation, or because you are ill.

Outlook Out of Office message

If you know in advance you will be out of the office, it is important to use the Outlook Out of Office message. When creating an Out of Office message, be sure to include the dates you will be gone, the day you will return, and designate an alternate contact. Remember to turn your Out of Office message off once you return to the office.

Telephone Voicemail message

If you know in advance you will be out of the office, it is important to change your Voicemail message to let callers know of your absence. Be sure to indicate the dates you will be gone, when you will return, and provide an alternate contact. Remember to change your voicemail message when you return to the office.

Receptionist

Let the IDPH Receptionist know if you will be out of the office for an extended period of time (for instance, you will be at a conference or on

vacation for several days). Let the receptionist know who your alternate contact will be. This allows the receptionist to forward any phone calls to the appropriate person, rather than making the caller go to your voicemail, only to find you are out of the office. This aids in customer service.

Working with the Media

Many government employees are reluctant to work with the media, but media relations are an important part of accomplishing our mission to promote and protect the public's health. Positive media interaction is necessary to convey the timely health messages that Iowa residents need to hear.

Reasons to work with the media:

- Helps raise visibility in the community
- Improves public health message dissemination
- Draws attention to important public health issues

Understanding the News Media

Effective media relations demand that IDPH maintains its reputation as a credible, accessible, expert source of public health information. Keep in mind, however, that what we think to be news may not be perceived as news by managing editors and TV news directors. Not every press release or media advisory will generate interest by the media.

Here are some criteria to help determine what professional journalists consider to be "news."

- Is the information significant to public health?
- How many readers/viewers will benefit from it?
- Is the story timely? (Does it refer to something upcoming or a recent development? Remember, last week's or even two days ago's news is no longer news today to news producers unless it impacts today.)
- Is it local or does it have local impact?
- Is the information accurate?
- Is the information new or different?

Journalists tend to see newsworthiness in the following situations:

- Sensation
- Celebrity
- Conflict
- Tragedy/Human Suffering
- Controversy
- Anniversary
- Irony
- Injustice
- Milestones

News coverage will increase if reporters can attach one of these situations to your news event. Framing your news pitches as part of one of the scenarios listed above will generate greater interest and result in wider coverage. Once you have the media's attention, you can work to ensure that the story is covered in a way that will help change behaviors and opinions on the health issue.

Avoiding Common Pitfalls of Working with the Media

- Don't talk too much. Stick to concise answers that address the question asked and reflect your key messages. If you over-answer, you risk being misquoted or having your key messages ignored.

- Keep it simple. Don't speak jargon or use technical terms. Like the public, most reporters are not formally educated in public health, so resist the temptation to look smart and try to keep your vocabulary at a level that a junior high school student would understand.

- Listen. Don't interrupt a reporter while the question is still being asked or you might find yourself answering a question that the reporter never intended to ask. If you don't understand a question for whatever reason, feel free to ask the reporter for clarification. And when in doubt, as always, bridge back to your key messages.

- Take all interviews seriously. If a college student from the university newspaper is interviewing you, there might be a

tendency to treat the event less seriously, but reporters from large media outlets often read or hear these "small" interviews. Often, they are prompted to call you with questions of their own. A good rule of thumb is, never say anything to a small media outlet reporter that you wouldn't also say to a New York Times reporter or a CNN correspondent.

The Differences between Media Advisories, Press Releases, Talking Points and PSAs

MEDIA ADVISORIES, sometimes also called NEWS ADVISORIES, are brief documents that answer the "5 W's" of journalism:

- Who
- What
- Where
- When
- Why

Media Advisories are used to announce an event such as an award ceremony, a press conference, a video opportunity, or any event that IDPH would like for the media to attend. These are sent via the IDPH News listserv, no more than one week before an event. A follow-up phone call to specific targeted media may be appropriate to ensure the alert has been received. Media Advisories require the same style and content approval process as Press Releases.

Media Advisory Example

WHO: IDPH
WHAT: Press Conference (News Conference)
WHEN: June 8, 2013
WHERE: 6th floor conference room, Lucas Building, Des Moines
WHY: IDPH to announce findings of a new statewide smoking prevalence survey

PRESS RELEASES

A typical press release begins with a "lead" paragraph to grab the reporter's or assignment desk's attention. The most effective press releases are no longer than one page in length, include one or more quotes from a SME and/or the IDPH Director, and include a web site where more information about the topic may be obtained. A release is not the same thing as an article; the intent of a release is to provide enough information or framework to get the reporter interested in covering the story. Depending on the level of interest and time available, the media outlet may choose to quote the release or portions of it, or call for more information or an interview.

TALKING POINTS

Talking Points are documents typically created for SMEs or LPHA. They include the significant information from a press release, but the emphasis is on key messages, research findings, and other data presented in an easy-to-read bullet point format. Talking Points are typically approved only by the SME, but may require approval from Bureau Chiefs, Division Director and the IDPH Director, depending on the sensitivity of the subject matter.

PUBLIC SERVICE ANNOUNCEMENTS (PSAs) and Public Service Programs

PSAs are free advertisements aired by broadcast outlets or published by print outlets. While they are run by media outlets free of charge, they may incur a production cost. Do not rely on PSAs to garner much public response because they are run infrequently—and sometimes not at all. Television and radio PSAs can air during non-peak hours (i.e. overnight), while print PSAs only run if the newspaper has room for them. Keep radio PSAs short and to the point.

Public Service Programs are short, typically pre-recorded segments for radio and television stations. Radio and television stations must offer public service programming to meet their licensing requirements. The Communication Director can work with media outlets to schedule these interviews. At least one month advance notice is required for scheduling public service program appearances.

Attachment 50

Public Health Response Plan Epidemiology

COMMUNICATIONS

Annex to the IDPH Emergency Response Plan

I. Purpose

- This document serves as an annex to the IDPH Public Health Emergency Response Plan.
- The goal of this Communication annex is to provide guidance to IDPH staff when establishing, maintaining, and supplying event specific communications and information with internal and external partners during a public health emergency.

II. Situation

- Emergencies and disasters may disable normal communication and warning capabilities.
- Emergencies and disasters may require uniform, specific public health messaging to IDPH staff as well as the public, response partners, healthcare providers, and healthcare facilities within Iowa's borders.

III. Assumptions

- IDPH response will be guided by the Department's Incident Management Structure (IMS) established for each event.
- Each event will dictate the communication method(s), types of information, frequency of communications, and audiences.
- Two or more methods to communication identified information will be available.
- Communication methods will be employed to provide messaging to identified at-risk and special needs population.
- Streamlined and effective communication channels provide better communication between all stakeholders.
- The IDPH Public Information Officer (PIO) will have appropriate education, training, and skills to fulfill operational role.

COMMUNICATIONS

Annex to the IDPH Emergency Response Plan

IV. Concept of Operations

- All messages and informational documents will be checked for appropriateness and accuracy following established IMS standards prior to dissemination.
- The IDPH Director or their designee, in close consultation with the State Public Health Medical Director or their designee, is the lead spokesperson for issues related to state public health policy.
- The IDPH PIO will collaborate and coordinate with the State Joint Information Center (JIC) when indicated.
- External communication methods will employ, but not be limited to, one or more of the following:
    - Call centers
        - Public
        - Health Care Providers
    - Email
    - Face-to-face
    - Health Alert Network
    - Internet web page
    - Mailings
    - Radio
    - Social media
    - Television
    - Webinar
    - Written documents/templates
- Internal communication methods will employ, but not be limited to, one or more of the following:
    - Email
    - Face-to-face
    - Health Alert Network
    - Intranet web page

- Radio
- Webinar
- Written documents

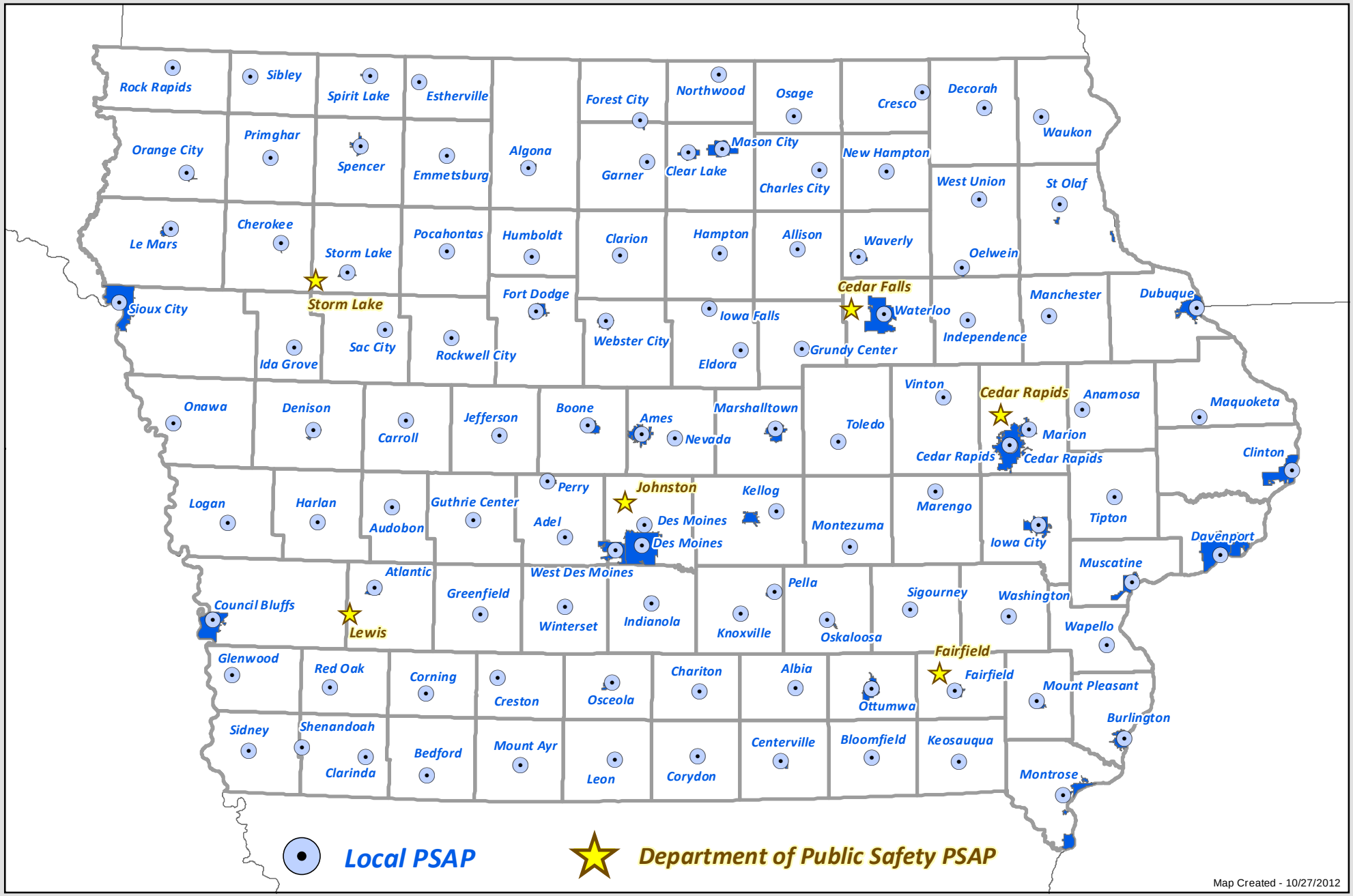
V. Organization and responsibilities

- The IDPH IMS Planning Section will be responsible for the coordination, development, approval, and selection of methods to disseminate information to local, state, and federal response partners.
- The IDPH PIO will be responsible for the coordination, development, approval, and selection of methods to disseminate public information and messages.
- The IDPH PIO will be responsible for the coordination, development, approval, and selection of methods to disseminate information and messages to IDPH staff not involved with the event response.
- The IDPH Logistical Section will be responsible for the dissemination of approved information and messages to response partners utilizing the identified communication methods and systems.
- The IDPH HAN Officer in collaboration with the IMS Logistical Section will be responsible for the coordination, development, and implementation of the Department's event specific communication plan.

Attachment 51

PSAP Locations

Public Safety Answering Points - Iowa



Attachment 52

Public Health Response Plan Epidemiology Annex

EPIDEMIOLOGY

Annex to the IDPH Emergency Response Plan

I. Purpose

- Annex to the IDPH Public Health Emergency Response Plan which guides epidemiological response during an emergency.

II. Situation

- The appearance of a novel or previously controlled or eradicated infectious agent or biological toxin.

III. Assumptions

- Disease, poisoning, and condition surveillance; case, cluster, and outbreak investigation; prevention and control; and data analysis are all core epidemiological functions.
- Public health response to most emergencies will require activities within one or more of the core functions.
- During day-to-day operations and during emergencies, information is constantly exchange between IDPH; healthcare providers (including hospitals); local public health partners; and laboratories.
- Certain infectious diseases can be transmitted from animals to humans and humans to animals (zoonotic) causing illnesses, injury and even death, and place an enormous financial burden on society.

IV. Concept of Operations

- Surveillance provides an ongoing picture of how the disease, poisoning, and condition are affecting the population of Iowa.
    - Establish early and ongoing surveillance systems to detect and monitor the event-specific disease, poisoning, or condition.
    - Consider surveillance of vectors and non-human hosts if appropriate.
    - Establish the case definition.
    - Determine whether active or passive surveillance is more appropriate.
    - Assess whether existing surveillance systems can be used or expanded
    - Engage all appropriate partners in surveillance efforts, such as health care providers, hospitals, and laboratories.
- Coordinate investigative activities related to contact tracing, interviewing, evaluation, and monitoring.

- In most situations, notify and pass responsibility for follow-up to LPHA.
- Work jointly with LPHA to coordinate the investigation and interview cases and contacts.
- Collect complete, congruent information from all cases and contacts.
- Store data in a manner that meets epidemiologic and reporting needs.

- Analyze data to determine how the event is affecting the population.
  - Analyze surveillance and investigative data to characterize the event and contribute to the development and implementation of prevention and control measure.
  - Utilize ongoing surveillance to determine the efficacy of the measures.
- Implement strategies to prevent and control the disease, poisoning, or condition.
  - Define the target audience.
  - Determine the most effective mechanism to communicate with the target audience.
  - Identify the appropriate prevention and control measures. The least restrictive most effective measures should be used. Examples include the use of quarantine, isolation, pharmaceutical intervention, travel restrictions, and social distancing.
  - Provide guidance to healthcare providers, hospitals, local government, law enforcement, EMS, private business, the general public, and other appropriate partners.

V. Organization and Responsibilities

- IDPH is responsible for ensuring that appropriate epidemiological activities are completed.
- Local public health agencies have the capacity to perform some of the core epidemiological functions, but others are performed jointly with IDPH.
- IDPH will either complete the epidemiological activities directly or will support local public health completion.
- Iowa Department of Agriculture and Land Stewardship (IDALS) and the Iowa Department of Natural Resources (DNR) will assume the lead state agency role when responding to a zoonotic disease outbreak and Iowa Department of Public Health (IDPH) will have supportive role.

VI. Direction, Control, and Coordination

EPIDEMIOLOGY

Annex to the IDPH Emergency Response Plan

- This annex will be activated when the State Epidemiologist, in consultation with the Department Director, determines that the Department's epidemiological response exceeds the Department's day-to-day epidemiological capacity.
- If the Incident Management Structure Annex is activated, direction for epidemiological activities will come from the Operations Section Chief.
- If the Incident Management Structure Annex is not activated, direction for epidemiological activities will come from the State Epidemiologist.

VII. Disaster Intelligence

- Information may be exchanges with CDC; health departments in other states; the Iowa Fusion Center; other state agencies in Iowa, as appropriate (e.g. DNR, DIA, SHL and IDALS; and various public health partners).

VIII. Administration, Finance, and Logistics

IX. Authorities

X. References

- Iowa Code Chapter 139A
- Iowa Administrative Code 641: Chapter 1
- The Epi Manual: Guide to Surveillance, Investigation, and Reporting (IDPH)
- The Foodborne Outbreak Investigation Manual (IDPH)

Attachment 53

HPP Capabilities and Functions

HPP Capabilities and Functions Applicable to EMS
March 2012

Capability 1: Healthcare System Preparedness

Function 1: Develop, refine, or sustain Healthcare Coalitions

Develop, refine, or sustain Healthcare Coalitions consisting of a collaborative network of healthcare organizations and their respective public and private sector response partners within a defined region. Healthcare Coalitions serve as a multi-agency coordinating group that assists Emergency Management and Emergency Support Function (ESF) #8 with preparedness, response, recovery, and mitigation activities related to healthcare organization disaster operations. The primary function of the Healthcare Coalition includes sub-state regional, healthcare system emergency preparedness activities involving the member organizations. Healthcare Coalitions also may provide multi-agency coordination to interface with the appropriate level of emergency operations in order to assist with the provision of situational awareness and the coordination of resources for healthcare organizations during a response.

Function Alignment:

- PHEP Capability 1, Community Preparedness; Function 2: Build community partnerships to support health preparedness
- PHEP Capability 1, Community Preparedness; Function 3: Engage with community organizations to foster public health, medical, and mental/behavioral health social networks

Task 1 Form a collaborative preparedness planning group that provides integration, coordination, and organization for the purpose of regional healthcare preparedness activities and response coordination

Task 2 Provide a regional healthcare multi-agency coordination function to share incident specific healthcare situational awareness to assist with resource coordination during response and recovery activities

P1. Healthcare Coalition regional boundaries

The State and Healthcare Coalition member organizations identify the geographic boundaries of the Healthcare Coalition. Healthcare Coalitions are developed around or within a functional service region/area based on unique needs of that region/area. The participation of the Healthcare Coalition is evidenced by written documents (e.g., charters, by laws or other supporting evidence based documents) that establish the Healthcare Coalition for the purpose of disaster preparedness. Examples of a region or area may include:

- Healthcare service catchment area
- Trauma region
- Emergency Medical Service (EMS) region
- Regional Coordinating Hospital region
    - Public Health region/district
    - County jurisdiction
    - Emergency Management Agency (EMA) region
- Other type of functional service region

P2. Healthcare Coalition primary members

Healthcare organization participation in emergency management preparedness and planning may include formation of Healthcare Coalitions as a component of a larger planning organization or region (e.g., EMS or EMA regions). This may also include supporting the healthcare organizations to form Healthcare Coalitions around healthcare delivery areas (e.g., Regional Coordinating Hospital Region, etc.) and obtaining input for preparedness from relevant response organizations and stakeholders. The State role in Healthcare Coalitions is to form a partnership with or to provide support for healthcare organizations in the effort for multi-agency coordination for preparedness and response.

P3. Healthcare Coalition essential partner memberships

The State and Healthcare Coalition member organizations encourage the development of essential partner memberships from the community's healthcare organizations and response partners. These memberships are essential for ensuring the coordination of preparedness, response, and recovery activities. Memberships may be dependent on the area, participant availability, and relevance to the Healthcare Coalition. Prospective partners to engage (assuming they are not already members):

- Hospitals and other healthcare providers
- EMS providers
- Emergency Management/Public Safety
- Long-term care providers
- Mental/behavioral health providers
- Private entities associated with healthcare (e.g., Hospital associations)
- Specialty service providers (e.g., dialysis, pediatrics, woman's health, stand alone surgery, urgent care)
    - Support service providers (e.g., laboratories, pharmacies, blood banks, poison control)
    - Primary care providers

Reference: Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness January 2012

- Community Health Centers
- Public health
- Tribal Healthcare
- Federal entities (e.g., NDMS, VA hospitals, IHS facilities, Department of Defense facilities)

Note: Active membership from these constituencies are evidenced by written documents such as MOUs, MAAs, IAAs, letters of agreement, charters, or other supporting evidence documents.

Function 2: Coordinate healthcare planning to prepare the healthcare system for a disaster

Coordinate with emergency management to develop local and state emergency operations plans that address the concerns and unique needs of healthcare organizations. Plans should encompass the ability to deliver essential healthcare services during a response. This includes the assessment phases of planning to determine needs and priorities of healthcare organizations and the development of operational courses of action used during responses.

Task 1 Engage relevant response and healthcare partners to assess the probability of hazards deemed likely to affect the healthcare delivery capability within a geographic area and prioritize response and mitigation activities given available resources
Task 2 Engage healthcare partners to coordinate healthcare planning efforts with local and state emergency operations planning to integrate healthcare organization priorities and unique needs into response and recovery operations

P2. Healthcare System disaster planning

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, collaborate to develop local and state all-hazards and ESF #8 plans. Plans should include, but are not limited to the following elements that:

- Include healthcare organizations objectives and priorities for response based on the HVA and risk assessment
- Assist healthcare organizations to perform capabilities required to prevent, protect against, respond to, and recover from all-hazards events when and where they are needed
- Coordinate vertically and horizontally with appropriate departments, agencies, and jurisdictions
- Provide a process to request local, state, and Federal assistance for healthcare organizations
- Provide the processes for requesting assistance from community partners and stakeholders and other healthcare organizations
- Coordinate healthcare organization operations with the local or state emergency operations center to assist with disaster response
- Define healthcare organization roles and responsibilities for response
- Coordinate the development of annexes that include specific healthcare delivery priorities including but not limited to:
  —Medical Surge Management
  —Information Management
  —Communications
  —Continuity of Operations
  —Fatality Management

Function 3: Identify and prioritize essential healthcare assets and services

Identify and prioritize healthcare assets and essential services within a healthcare delivery area or region (Healthcare Coalition area). Coordinate planning to protect and enhance priority healthcare assets and essential services in order to ensure continued healthcare delivery to the community during a disaster.

Task 1 Identify and prioritize the essential healthcare assets and services of the community
Task 2 Coordinate planning and preventative measures to assist with the protection of prioritized healthcare assets and essential services

P1. Identify and prioritize critical healthcare assets and essential services

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, perform community healthcare assessments to identify and prioritize healthcare assets and essential services that are vital for healthcare delivery. These assessments should identify the following critical services and key resources (not inclusive):

- Critical medical services (e.g., trauma, radiology, critical care, surgery, pediatrics, EMS, decontamination, isolation)
- Critical medical support services (e.g., patient transport services, pharmacy, blood banks, laboratory, medical gas suppliers)
- Critical facility management services (e.g., power, water, sanitation, generators, heating, ventilation, and air conditioning (HVAC), elevators)
- Critical healthcare information systems for information management/communications (e.g., failover and back up, remote site hosting)
- Key healthcare resources (e.g., staffing, equipment, beds, medical supply, pharmaceuticals)

P2. Priority healthcare assets and essential services planning

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain resource management processes to assist healthcare organizations with resources support. This support should assist healthcare organizations to maintain the priority healthcare assets and continue essential services during a response.

Reference: Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness January 2012

Coordinated plans for resource assistance (e.g., space, staffing, equipment, supplies, services and systems) should include but is not limited to the following elements:

- Processes for healthcare organizations to quickly restore essential medical services in the aftermath of an incident
- Strategies for resource allocation that assist with the continued delivery of essential services during response
- Processes for healthcare organizations to request assistance and activate resource agreements to improve access to resources and emergency supply lines
  —The objective should be to extend operational ability well past the 96 hour standard (The Joint Commission EM.02.01.01 EP3) and if possible up to recovery
- Options for healthcare organizations to obtain assistance from a local or regional cache if available
- Processes to coordinate with healthcare organizations to assist with the movement of patients to alternate locations to receive critical medical treatment or evaluation (e.g., radiology, critical care)
- Processes to assist healthcare organizations with the decompression (clearing) of critical beds by assisting with the movement of patients to alternate facilities (For supporting information, please see Capability 10 — Medical Surge)
- Processes to assist healthcare organizations with the provision of special services/teams to support patient care and treatment (e.g., DMAT Teams, mobile radiology, mobile pharmacy, transportation, etc.)
- Processes to disseminate Federal-, state- and regional-based pharmaceutical caches and medical supplies

Function 4: Determine gaps in the healthcare preparedness and identify resources for mitigation of these gaps

Perform resource assessments and develop plans to assist healthcare organizations address gaps associated with planning, training, staffing, and equipping that improve resource availability during response and recovery. This is an ongoing process in the preparedness cycle guided by healthcare organization resource needs. These needs are based on the outcome of gap analysis, the evaluation of training, exercises, and actual incidents or events, and subsequent corrective actions.

Task 1 Perform a resource assessment by analyzing healthcare organization needs and evaluating exercises, training, and actual incidents or events to determine gaps and corrective action
Task 2 Deconflict resources by ensuring response resources are not over allocated to multiple stakeholders within the community

P1. Healthcare resource assessment

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, perform an healthcare organization resource assessment in order to identify:

- Healthcare organization resource gaps for incident response including those in:
  —Communication
  —Transportation
  —Manpower (e.g., stabilize/maintain staff after an event)
  —Equipment and supplies
  —Surge or alternate care space
  —Specialty services
  —Other resources identified by the gap analysis/corrective actions
- Categorization of the available assets within the region that could be used to address resource gaps
- Available resource assistance from accessible public or private caches
- Mutual aid agreements for resources from public and private sector (if the healthcare organization is willing to participate)
- Local, state, and Federal resources available through the appropriate request process
- Deconfliction of over allocated resources (competing priorities for the same resource at the same time)

Function 5: Coordinate training to assist healthcare responders to develop the necessary skills in order to respond

Coordinate training for healthcare responders and supporting agencies in order to provide the required knowledge, skills, and abilities needed to prepare and respond to a disaster. Training curriculums are based on assessments, strategies, improvement plans, and ongoing evaluation efforts. Training is coordinated with ongoing training initiatives from healthcare and response partners. Training should include appropriate National Incident Management System (NIMS) or equivalent training.

Task 1 Assist with the provision of National Incident Management System training for healthcare organizations in order to refine and improve response knowledge, skills, and abilities in accordance with the National Response Framework (NRF)
Task 2 Assist with the provision of training for healthcare organizations based on existing response gaps in order to improve and refine required response knowledge, skills, and abilities

P1. Healthcare organization — National Incident Management System (NIMS) training

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain healthcare strategies that assist healthcare organizations with NIMS training. This includes processes and strategies to:

- Promote NIMS adoption with healthcare organizations
- Support NIMS implementation with healthcare organizations

Reference: Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness January 2012

- Assist healthcare organizations to revise and update healthcare organization Emergency Operation Plans to incorporate NIMS and NRF components
- Assist healthcare organizations develop, refine, and sustain interagency mutual aid agreements, (e.g., agreements with public, private sector, and nongovernmental organizations)
- Assist healthcare organizations with FEMA 100, 200, and 700 level training or equivalent training
- Assist healthcare organizations with FEMA 800 level training or equivalent training
- Integrate NIMS concepts and principles into healthcare organization-related training and exercises
- Promote and encourage healthcare organization protocols, equipment, communication, and data interoperability to facilitate the collection and distribution of consistent and accurate information with state and local partners during an incident
- Promote the application of common and consistent terminology during response
- Ensure all emergency incidents, exercises, and preplanned (recurring/special) events are managed with a consistent application of ICS organizational structures, doctrine, processes, and procedures
- Assist healthcare organizations with adoption of the principle of Public Information, facilitated by the use of the Joint Information System (JIS) and Joint Information Center (JIC)

S1. Training to address healthcare gaps and corrective actions

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, provide training to address identified healthcare response gaps and corrective actions. Training should be based on the specific needs (i.e., knowledge, skills, and abilities) identified by healthcare organizations

Function 7: Coordinate with planning for at-risk individuals and those with special medical needs

Participate with planning to address at-risk individuals and those with special medical needs whose care can only occur at healthcare facilities. This includes coordination with public health and ESF#6 mass care planning to determine the transfer and transport options for individuals with special medical needs to and from shelters/healthcare facilities. It also includes continued involvement with public health planning initiatives for at-risk individuals with functional needs so that assistance or guidance can be provided to healthcare organizations regarding activity that may affect healthcare.

Task 1 Participate in the planning process that identifies and determines multiple care options for individuals with special medical needs that are not suitable for mass care shelters and require care at medical facilities during incidents
Task 2 Participate in coordinated planning with public health and ESF#6 agencies to determine protocols for the transfer of patients between mass care and healthcare settings during a disaster

P2. Special medical needs planning

The State and Healthcare Coalitions, in coordination with healthcare organizations, engage with the appropriate agencies and participate in planning for individuals having special medical needs and whose care can only occur at healthcare facilities. Plans should include:

- Courses of action to ensure individuals will be seen by the appropriate healthcare personnel during an incident
- Coordination with EMS to improve transport capabilities
- Coordination with alternative transportation capable of supporting individuals with special medical needs
- Coordination with public health and ESF#6 mass care planning to determine the transfer and transport options and protocols for individuals with special medical needs to and from shelters/healthcare facilities

Capability 6: Information Sharing

Function 1: Provide healthcare situational awareness that contributes to the incident common operating picture

Provide situational awareness regarding the status of healthcare delivery into the ongoing flow of information to assist with the creation of an incident common operating picture. This includes providing information to the full spectrum of healthcare partners. This encompasses the real time sharing of actionable information between healthcare organizations and incident management to assist decision makers with resource allocation and provide healthcare organizations with incident specific information.

Task 1 Before an incident, identify the essential elements of incident specific healthcare information that are timely, relevant, actionable, and can be reasonably delivered during the response
Task 2 Before, during, and after an incident, utilize coordinated information sharing protocols to receive and transmit timely, relevant, and actionable incident specific healthcare information to incident management during response and recovery

E1. Healthcare information systems

The State and Healthcare Coalitions, in coordination with healthcare organizations, should have or have access to information sharing system(s) that assist with the creation of an incident common operating picture. These systems should have the ability to:

- Integrate with local or state emergency operations information systems used for response
- Provide timely, relevant, and actionable healthcare information to the incident common operating picture
- Provide multijurisdictional and multidisciplinary incident related information to healthcare organizations
- Adhere to applicable local and state information technology regulations regarding the receipt and transmittal of information

Reference: Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness January 2012

Examples of information sharing systems that contribute to the incident common operating picture include but are not limited to the following:

- Bed tracking systems
- EMS information systems
- Health alert networks
- Patient tracking systems
    - 911 call centers and systems
    - Web-enabled emergency management communications systems
- Credentialing systems

P6. Patient tracking

The State and Healthcare Coalitions, in coordination with EMS, healthcare organizations, and emergency management, develop, refine, and sustain a process to track patients and/or have access to an electronic patient tracking system during an incident. This should include but is not limited to the ability to:

- Identify system users that have the appropriate authority/access permissions for electronic systems
- Access relevant and available aggregate patient tracking data from EMS and healthcare organizations (e.g., number of patients requiring receiving facilities, requiring transfer services)
- Integrate the aggregate patient tracking data into the local, state and/or Federal incident common operating picture
- Adhere to mandatory patient confidentiality regulations
- Integrate with the Federal patient tracking system of record

E3. Patient tracking system

The State and Healthcare Coalitions, in coordination with EMS and healthcare organizations, should have or have access to a patient tracking system. The system should have the ability to:

- Maintain operational status during an incident
- Integrate with the Federal patient tracking system of record
- Satisfy regulatory/confidentiality requirements
- Track patients from entry into the healthcare system (EMS or facility level) through discharge
- Integrate data into the local, state and Federal incident common operating picture

Capability 10: Medical Surge

Function 2: Coordinate integrated healthcare surge operations with pre-hospital Emergency Medical Services (EMS) operations

Coordination between the State, healthcare organizations, and Healthcare Coalitions with EMS operations and medical oversight to develop, refine, and sustain protocols for information sharing and communications. These protocols should assist with the coordination of transport decisions and options during a medical surge incident. These protocols also assist healthcare organizations understand the EMS disaster triage, transport, documentation, and CBRNE treatment methodologies during mass casualty incidents resulting in medical surge.

Task 1 Promote information sharing processes that enable healthcare organizations to track the status and transport of patients (situational awareness) from EMS during medical surge incidents
Task 2 Provide training and guidance to encourage healthcare organizations to understand EMS disaster triage protocols and CBRNE treatment protocols that assist with the transition of disaster patients from the field to the facility

P1. Healthcare organization coordination with EMS during response

The State and Healthcare Coalitions, in coordination with public and private EMS, healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan that includes processes to coordinate information sharing and surge resources. These processes should ensure the ability to:

- Provide ongoing communication to healthcare organizations about EMS activity during surge operations
- Coordinate transport decisions vertically and horizontally during medical surge incidents
- Provide healthcare organizations with situational awareness about the status of the transport and tracking of patients from EMS
- Provide situational awareness of healthcare organizations' patient receiving status that assists with coordination for pre-hospital transport decisions (e.g., primary and alternate facility receiving status/availability)
- Assist healthcare organizations to notify local, state or regional (Healthcare Coalition) personnel to request support
- Contact relevant EMS agencies within the region
- Inform EMS of bed status when requested (if not electronically available)
- Assist EMS and healthcare organizations make decisions to divert en route EMS facilities with the equivalent levels of care based on bed status and patient tracking information
- Provide equal access for the transport of at-risk individuals and those with special medical needs
- Assist with the implementation of existing statewide mutual aid plans to deploy EMS units in jurisdictions/regions they do not normally cover, in response to a mass casualty incident

Reference: Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness January 2012

P2. Coordinated disaster protocols for triage, transport, documentation, CBRNE

The State and Healthcare Coalitions, in coordination with public and private EMS, healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain a plan to assist with training and guidance to understand the local disaster EMS protocols for triage, transport, documentation, and decontamination. Plans may include but are not limited to the following elements:

- Coordination with local and/or state EMS medical direction/oversight to ensure the most current guidance regarding EMS disaster triage, transport, and CBRNE treatment is provided to healthcare organizations to include:
  - —Triage methodologies
  - —Protocols for:
    - >>Transport of mass casualties during medical surge (e.g., transport patients from an incident scene or from local hospitals to healthcare facilities in adjacent jurisdictions within or near the affected jurisdiction, and to nearby staging areas for transport to more distant healthcare facilities)
    - >>Disaster documentation during incident
    - >>CBRNE exposure care
- A process for the promotion and dissemination of EMS protocols and methodologies to healthcare organizations
- Development of coordinated training and exercises between EMS and healthcare organizations

S1. Training on local EMS disaster triage methodologies

The State and Healthcare Coalitions, in coordination with public and private EMS, healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, assess the need to provide training for healthcare organizations that includes the local EMS disaster triage methodology. Training should focus on developing a common understanding of critical operations between the healthcare organization and EMS.

S2. Coordinated CBRNE training

The State and Healthcare Coalitions, in coordination with public and private EMS, healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, assess the need to provide training for healthcare organizations that includes the local EMS CBRNE protocols. Training should focus on developing a common understanding of critical operations between the healthcare organization and EMS.

P3. Assist healthcare organizations maximize surge capacity

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners and stakeholders, develop, refine, and sustain a plan to maximize surge capacity for medical surge incidents. This plan may include but is not limited to the following elements:

- Surge Assessment:
  - —Pre-incident assessment of normal operating capacity for healthcare organizations within the healthcare delivery area
  - —Pre-incident estimate of surge casualties (i.e., medical casualties, mental/behavioral health casualties)[estimates are based on the risk assessment — For more information, please see Capability 1 – Healthcare Preparedness]
  - —Pre-incident assessment of available resources to address surge estimates
  - —Development of surge capacity indicators that would trigger different aspects of the medical surge plan (e.g., surge in place strategies; early discharge, cancelled elective surgeries; augmented personnel; extra shifts, volunteers; established alternate care sites or activated mobile units; requested mutual aid)
  - —Processes to immediately identify an increase in medical surge status during an incident (e.g., medical, mental/behavioral health, concerned individuals)
- Decompression (clear) of critical beds:
  - —Develop, refine, sustain, and implement processes that assist healthcare organizations with daily, continuous, triage of admitted patients and discharge planning to permit the safe discharge of less acute patients, ensuring twenty percent acute bed availability in the event of a disaster
  - —Coordination with non-acute care facilities to accept patients to clear beds (e.g., Community Health Centers, SNFs, and home healthcare)
  - —State led coordination with Veterans Health Administration and Department of Defense to establish options for assistance with patient care, transfer of patients, and additional assistance during medical surge operations
  - —Development of viable options to share healthcare assets (e.g., beds, staffing, equipment) between healthcare organizations
  - —Protocols to request immediate resources needed to decompress beds (e.g., transport, staffing, space, equipment and supply needs)
  - —Develop, refine, and sustain patient movement options to address psychiatric beds, involuntary holds, and patients with exposure to CBRNE
- Locally available resource assistance (mobile equipment and caches of supplies):
  - —Implementation of state or regional resource assistance (if available) to include plans to deploy mobile medical assets and utilize caches of medical supplies
- Alternate surge sites (healthcare organization or Healthcare Coalition):

–Protocols to assist with activation of alternate surge sites if requested by the healthcare organization. This may include the following elements:
>Processes to supply surge tents or trailers and equipment to serve as additional treatment areas for patients when available (e.g., mobile hospital)
>Processes to assist healthcare organizations request staffing to operate surge sites when requested and available (e.g., mobile medical team)
>Coordination of alternate surge sites with state and local EMS authorities to ensure these sites can receive and transfer EMS ambulance patients
>Coordination of assets requested through the Emergency Management Assistance Compact
>Coordination of Federal assets (e.g., Federal Medical Stations, Disaster Medical Assistance Team)

- Alternate care sites:
  –Coordination with alternate care sites developed at non-healthcare facilities for the surge of individuals that do not require care at healthcare organizations' surge sites
- Mass death in healthcare facilities:
  –Coordination with fatality management planning to address mass deaths and the ability to store human remains that occur at healthcare facilities (For supporting information, please see Capability 5 – Fatality Management)
  –Coordination of planning to address surges of concerned citizens at healthcare facilities that may occur during community mass fatalities (For supporting information, please see Capability 5 – Fatality Management)
- Volunteers and other staff resources:
  –Develop, refine, and sustain processes that assist healthcare organizations to share staff during medical surge operations. This includes the credentialing process prior to an incident
  –Implementation of plans to utilize the local volunteer management process to gain access to trained, credentialed staff to assist with patient care and other duties during surge operations (For more information, please see Capability 15: Volunteer Management)
- Crisis standards of care:
  –State led processes to guide healthcare organizations during crisis standards of care when resources are scarce and when requested (For supporting information, please see Function 4 in Capability 10)

P6. Healthcare organization patient transport assistance

The State and Healthcare Coalitions, in coordination with healthcare organizations, emergency management, ESF #8, relevant response partners, and stakeholders, develop, refine, and sustain patient transport processes for medical surge incidents. These processes address patient transport needs above routine healthcare organization transport agreements due to the number and severity of patients. The methods used to transport may vary, however, the medical and legal obligations for patient transport should be considered and factored into transportation processes. The coordination of multiple transport options include but are not limited to following considerations:

- Air, ground, and sea options
- Public and private options
- National guard collaboration
- Federal Coordinating Centers (FCC) and National Disaster Medical System collaboration (e.g., coordination with FCC to establish patient movement protocols between the private sector and the Federal patient movement system)
- Volunteer agencies
- Family members
- Additional innovative options (just-in-time options)

Transportation processes should adhere to the appropriate regulatory guidance:

- Emergency Medical Treatment and Active Labor Act (EMTALA) and
- The Health Insurance Portability and Accountability Act of 1996 (HIPPA)
- Other medical and legal guides to transporting patients and transferring care

P9. Decontamination assistance to healthcare organizations

The State and Healthcare Coalitions, in coordination with healthcare organizations, Hazardous Materials (HazMat) response authorities, ESF #8, and relevant response partners, develop, refine, and sustain decontamination plans to provide assistance during incidents that overwhelm the existing decontamination ability of the healthcare organization. Plans should include but are not limited to the following elements:

- Assessments of the decontamination capability of healthcare organizations
- Assessments of the anticipated number of casualties resulting from a CBRNE exposure that are expected to seek treatment at healthcare organizations without prior decontamination (based on local risk assessments)
- Develop, refine, and sustain strategies to provide assistance to healthcare organizations with decontamination planning, equipping, or training to meet the anticipated need
- Processes to request decontamination assets during response, if available
- Coordination with local EMS decontamination units and HazMat units to support decontamination surges that overwhelm healthcare organizations
- Processes to coordinate healthcare organization decontamination procedures with state, regional and local HazMat response teams
- Processes for healthcare organizations to return assets that were provided (e.g., cleaning, resupply)

Reference: Healthcare Preparedness Capabilities: National Guidance for Healthcare System Preparedness January 2012

Attachment 54

CQI Policy and Appointments

EMS SERVICE OR SYSTEM

CONTINUOUS QUALITY IMPROVEMENT (CQI)

POLICY MANUAL & DESIGNEE APPOINTMENTS

General Purpose: This CQI Policy establishes guidelines for the implementation of a program to support EMS providers as they strive to provide excellent patient care. These policies intend to provide direction to set measurable goals and define minimum performance standards for the individuals and service. This consistent, fair evaluation practice will provide the routine feedback every provider deserves. This policy meets or exceeds the requirements of Iowa Code Chapter 147A: Emergency Medical Care– Trauma Care and the Iowa Administrative Code (IAC): 641—132.8(147A) Service program levels of care and staffing standards and 641—132.9(147A) Service program—off-line medical direction.

General Procedure: The interaction of the physician, service leadership and providers is critical for the success of this CQI program. All staff must understand their role, responsibilities and duties as part of the CQI team. Every team member shall receive an initial orientation to this policy and be provided with an opportunity for input and updates when amended.

Email an electronic copy or mail this signed policy to your Regional EMS Coordinator.

Approval & Affirmation: The signatures within this document indicate approval of the policy and agreement to perform the duties as an official designee of the physician medical director.

SERVICE NAME: _____

SERVICE LOCATION:_____

Policy Approval	Print Name	Signature	Date
Medical Director			
Service or System Director			

Designee Appointment: The medical director shall conduct CQI activities or appoint individual(s) to ensure written audits of the patient care reports are completed; staff orientation, CEH and skill competencies are conducted and documented; and actions plan, follow-up and resolution are done as defined within this policy.

I acknowledge that I am appointed, by the medical director, as an official CQI designee. I understand my duties and will implement and maintain this CQI program as directed.

Print Name	Signature	Date

SECTION A: SCOPE OF PRACTICE

Policy: EMS providers shall provide care within the current Iowa Scope of Practice and as authorized, in writing, by the medical director.

Procedure:

1. EMS providers shall review the Scope of Practice for EMS Providers during initial orientation to the service and whenever the scope is officially amended.

2. The service shall maintain documentation of initial and periodic staff reviews of the Scope of Practice.

3. EMS providers shall provide care within the Scope of Practice for their certification level limited by the service program level of authorization.

SECTION B: PROTOCOLS

Policy: EMS providers shall deliver care as directed in the medical director authorized protocols.

Procedure:

1. The medical director shall review and authorize all protocol modifications including any state and/or local protocol changes.

2. The service shall ensure the Regional EMS Coordinator promptly receives the medical director signed protocol authorization, change pages and medication list each time the protocols are amended.

3. The EMS service will maintain documentation of protocol education for EMS providers.

4. The EMS service will provide and document training after the medical director has authorized any state or local changes to the protocols.

5. EMS providers shall deliver care as directed within the approved patient care protocols.

6. Treatment rendered that deviates from the approved protocols must be documented on the patient care report (PCR) and reported to the service director and to the attention of the medical director.

SECTION C: INITIAL ORIENTATION PROCESS

Policy: New staff shall complete a standard credentialing orientation process that includes baseline medical competencies.

Procedure:

1. The service shall maintain documentation of new staff orientation under the direction of an assigned preceptor using the service Orientation Form.

2. As a minimum, the orientation will include training on all service agreements, policies, procedures and protocols. (e.g., current Protocols, CQI Policy, Emergency Driving & Communication Policy, Pharmacy Agreement and Policies & Procedures, etc.)

3. The service shall maintain documentation of RN or PA equivalency training and forms as required by the Bureau of EMS.

4. The completed Orientation Form shall be kept on file.

SECTION D: SKILL MAINTENANCE

Policy: All staff shall maintain skill competency for all procedures & equipment as allowed by the medical director.

Procedure:

1. All staff will promptly complete assigned ongoing skill competencies, within their Scope of Practice, as defined by the medical director.

2. The service will maintain documentation of completion of the skill competencies as designated by the medical director within the established timeframes.

SAMPLE CRITERIA

The medical director may add or delete criteria to meet the unique needs of the service.

BASIC SKILLS	FREQUENCY OF PRACTICE Q = quarterly, B = biannually, A = annually, NA = not applicable			
	Q	**B**	**A**	**NA**
ASSESSMENT: vital signs for all ages				
ADULT & PEDIATRIC AIRWAY: BVM, suctioning, oral & nasal, and/or per protocol				
CARDIAC ARREST MANAGEMENT: CPR, AED for all age groups				
MEDICATION ADMINISTRATION: over-the-counter, patient assisted, and/or per protocol				
IMMOBILIZATION DEVICES: cervical collars, long and short boards, extremity splints including traction				
ADVANCED SKILLS	**Q**	**B**	**A**	**NA**
ADULT & PEDIATRIC AIRWAY: bridge, double-lumen, endotracheal				
ADULT & PEDIATRIC IV/IO ACCESS				

NEEDLE CRICOTHYROTOMY				
NEEDLE THORACOSTOMY				

SECTION E: CONTINUING EDUCATION

Policy: All staff will maintain the appropriate EMS education to be prepared to provide comprehensive, competent, quality care to all patients.

Procedure:

1. EMS staff will maintain current Iowa EMS certification, Healthcare Provider CPR and emergency driving and communications training.

2. Drivers on the roster will maintain Healthcare Provider CPR and emergency driving and communications training.

3. All staff listed on the roster shall promptly provide the service director with the documentation required to maintain current personnel and/or training files (e.g.; CPR card, driver's license, etc.)

4. All staff will document course completion in any or all of the following courses, within their scope of practice, as assigned by the medical director.

SAMPLE CRITERIA

The medical director may add or delete criteria to meet the unique needs of the service.

COURSE DESCRIPTION	YES	NO
Advanced Cardiac Life Support (ACLS)		
Pediatric Advanced Life Support (PALS)		

SECTION F: WRITTEN MEDICAL AUDITS

Policy: The EMS service shall ensure that written medical audits review patient care & protocol compliance, response time & time spent at the scene, system response, and completeness of documentation. Providers shall receive timely feedback on audited PCR's.

Procedure:

1. Within 24 hours, the responding staff shall complete and file a written patient care report and ensure that the receiving facility has a copy of the completed PCR.

2. Any significant deviation from the approved protocols or standard of care will be brought to the attention of the CQI appointee.

3. Any discussion of EMS responses shall be confidential and limited to current staff.

4. Assigned CQI auditors shall perform written audits quarterly.

5. An audit shall be complete when it is signed by the PCR author, reviewed by responding staff and the auditor is satisfied with the loop closure.

6. The completed written audit shall be kept on file or recorded into a written audit activity log.

7. If there are no patient encounters that meet the assigned criteria during the quarter, the CQI appointee will select a percent of calls to audit or a number of calls per provider or any method that ensures that providers receive written feedback on their documentation and performance.

SAMPLE CRITERIA

The medical director may add or delete criteria to meet the unique needs of the service.

The medical director shall review written audits quarterly
or sooner at the discretion of the CQI appointee.

Type of Response	Yes	No
All Responses		
Cardiac Arrest		
Trauma Patients with Time-Critical Injury		
Unconsciousness		
Pediatric Respiratory Difficulty		
Stroke Symptoms		
Death at Scene		
Refusal of Transport		
Deviation from Approved Protocol		

SECTION G: FOLLOW-UP & LOOP CLOSURE

Policy: The medical director and the service director shall utilize a written action plan, as needed, to address personnel, vehicle, equipment and system challenges.

Procedure:

1. The action plan shall be implemented when any of the following occur: significant deviation from written protocol or standard of care, delay of response or treatment, vehicle or equipment failure and/or system difficulty.

2. The medical director and service director shall develop and implement a written action plan and monitor the situation until the desired improvement is achieved.

SECTION H: MEASURABLE OUTCOMES

Policy: The medical director, in consultation with the staff, shall establish measurable outcomes consistent with strategic planning goals and unique needs of the local

EMS system to appraise the overall effectiveness and efficiency of the EMS system.

Procedure:

1. The service director or CQI designee shall compile an Annual Report for the service owner, staff and medical director. As a minimum, the Annual Report shall include:
   a) Total number of responses
   b) Average time from first page to en route
   c) Average time from first page to arrival at the scene
   d) For ambulance services: average scene times for medical and trauma.

2) In addition to response and scene times, the staff and medical director shall select at least one additional indicator to measure and include in the Annual Report.

SAMPLE CRITERIA

The medical director may add or delete criteria to meet the unique needs of the service.

Indicator	Yes	No
One full set of vital signs and the GCS will be completed 95% of adult and pediatric patients.		
Multiple, complete sets of vital signs and the GCS will be documented on 75% of the patients with transportation times greater than 15 minutes.		
Eligible chest pain patients will receive aspirin (ASA) per protocol before transport 90% of the time.		
90% of suspected stroke patients will receive a neurological examination per protocol.		
Scene time for trauma patients with time critical injuries shall be 10 minutes or less 90% of the time.		
Reason for use of lights & sirens to the scene and to the destination will be documented on 75% of responses.		

SECTION I: SUPPLIES &EQUIPMENT MAINTENANCE

Policy: The service will maintain equipment in a manner that ensures equipment is clean and functions well. Equipment maintenance shall, at a minimum, follow the manufacturer's recommendations. Supplies shall be routinely inventoried to ensure appropriate quantities are available and not outdated.

Procedure:

1. Any equipment used shall be cleaned and supplies replaced following each response.

2. Assigned staff shall complete a detailed equipment checklist (including quantities and outdates) monthly, as a minimum.

3. Any deficiencies shall be documented on the checklist and brought to the attention of the service director for corrective action(s) and the resolution shall be documented.

4. Documentation of equipment checks and maintenance shall be kept on file.

SECTION J: VEHICLE MAINTENANCE

Policy: Preventive maintenance shall be routinely conducted on all vehicles to limit downtime, minimize inadvertent failures and reduce maintenance costs.

Procedure:

1. Vehicles shall be maintained according to manufacturer's recommendations.

2. Assigned staff shall complete and document a detailed vehicle checklist as a minimum, monthly.

3. Any deficiencies shall be documented on the checklist and brought to the attention of the service director for corrective action(s) and the resolution shall be documented.

4. Documentation of vehicle checks and maintenance shall be kept on file.

SECTION K: PHARMACY POLICIES & PROCEDURES

Policy: Certified EMS providers shall read and provide care within the service program's pharmacy agreement, policies & procedures, as authorized in writing.

Procedure:

1. The service director and the medical director and/or pharmacist-in-charge of the base pharmacy shall maintain agreements and policies & procedures that comply with Pharmacy Administrative Code Chapter 11[657] – Drugs in Emergency Medical Service Programs.

2. The service will maintain documentation of staff training of the pharmacy policies & procedures.

3. The service will maintain documentation of staff training of all over-the-counter and other medications authorized within the protocols.

4. The service will provide and document training each time the pharmacy policies & procedures or authorized drugs are modified.

5. All EMS providers must follow the approved pharmacy policies & procedures.

6. Any deviations from the service program pharmacy policies and procedures shall be brought to the attention of the service program director.

Attachment 55

Patient Care Report Audit Form

This document is provided by the Iowa Bureau of Emergency and Trauma Services. It is not mandatory that you use this form. Thoroughly read this form and make changes that reflect the current practices of your service.
Prior to implementing this policy, remove this header: double-click to open, CTRL+A to highlight and hit DELETE.
Double-click within the body of the document to close the header.

PATIENT CARE REPORT (PCR) AUDIT FORM

Service Name:	Location:
Incident Date: 29T	Audit Date: 29T
Report Number:	Auditor:
Report Author:	Additional Staff:

S = satisfactory (element included, clear, and understandable) **NA** = not applicable
I = improvement needed (element omitted, vague or unclear)

PROVIDE WRITTEN COMMMENT BELOW FOR ALL "IMPROVEMENT NEEDED" OR "NO" NOTATIONS

DOCUMENTATION ELEMENTS	S	I	NA	COMMENTS
Service/staff identification	☐	☐	☐	
Patient identification	☐	☐	☐	
Scene and time information	☐	☐	☐	
Chief complaint: documented or obvious	☐	☐	☐	
Safety equipment used by patient	☐	☐	☐	
History including MOI or NOI	☐	☐	☐	
Vital signs and physical exam findings	☐	☐	☐	
Care rendered prior to arrival	☐	☐	☐	
Procedures and treatments	☐	☐	☐	
Reason for use of lights & siren to and/or from the scene documented	☐	☐	☐	

CLINICAL AUDIT MEASURES	YES	NO	N/A	COMMENTS
Response time acceptable	☐	☐	☐	
Scene time acceptable	☐	☐	☐	
Transport time acceptable	☐	☐	☐	
Destination decision appropriate	☐	☐	☐	
Tiered response time appropriate	☐	☐	☐	
Appropriate protocol followed	☐	☐	☐	
Overall documentation adequate	☐	☐	☐	
Treatment/procedures appropriate	☐	☐	☐	
Utilization of lights/siren appropriate	☐	☐	☐	
Patient outcome as expected	☐	☐	☐	
Medical Director review needed	☐	☐	☐	
Follow-up necessary **(USE ACTION PLAN)**	☐	☐	☐	

WRITTEN AUDIT COMMENTS PAGE

AUDITOR		
Type or Print Name	Signature	Date
Comments:		

MEDICAL DIRECTOR		
Type or Print Name	Signature	Date
Comments:		

REPORT AUTHOR		
Type or Print Name	Signature	Date
Comments:		

ADDITIONAL RESPONDING STAFF MEMBER		
Type or Print Name	Signature	Date
Comments:		

ADDITIONAL RESPONDING STAFF MEMBER		
Type or Print Name	Signature	Date
Comments:		

Attachment 56

Written Audit Activity Log

SAMPLE – SAMPLE – SAMPLE – SAMPLE – SAMPLE

This document is provided by the Iowa Bureau of Emergency and Trauma Services. It is not mandatory that you use this form. Thoroughly read this form and make changes that reflect the current practices of your service. Prior to implementing this policy, remove this header: double-click to open, CTRL+A to highlight and select DELETE. Double-click within the body of the document to close the header.

WRITTEN AUDIT ACTIVITY AND FOLLOW-UP LOG

Use this form to track written audits that have been through loop closure.
Maintain this log to demonstrate that audits have been conducted quarterly or sooner per the service CQI policy.

SERVICE NAME: QUARTER: YEAR:

Date of Incident	Unique Patient Care Report Identifier	**Chief Complaint** *select from dropdown menu*	Date Written Audit Conducted	Date Report Author and Staff Reviewed the Written Audit	Date Medical Director Reviewed (if applicable)
Click here to enter a date.		Choose an item.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
Click here to enter a date.		Choose an item.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
Click here to enter a date.		Choose an item.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
Click here to enter a date.		Choose an item.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
Click here to enter a date.		Choose an item.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
Click here to enter a date.		Choose an item.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
Click here to enter a date.		Choose an item.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
Click here to enter a date.		Choose an item.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
Click here to enter a date.		Choose an item.	Click here to enter a date.		Click here to enter a date.
Click here to enter a date.		Choose an item.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.
Click here to enter a date.		Choose an item.	Click here to enter a date.	Click here to enter a date.	Click here to enter a date.

Attachment 57

Annual EMS Report Template

SAMPLE – SAMPLE – SAMPLE – SAMPLE – SAMPLE

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(INSERT YEAR) ANNUAL EMS REPORT

Complete this form and share with the service owner, medical director and staff. Keep copies on file.

Service/System Name			
Location(s)			
	Print Name:	Signature:	Date:
Service Owner			
Medical Director			
Service Director			

Types of Responses	Number
Cancelled	
Standby (sporting and school events, fairs, rodeos, etc.)	
No patient found	
Treat and release	
Non-emergency transports	
Emergency transports	
Total number of responses for EMS	

Times for 911 Calls	Minutes
Average time from first page to enroute	
Average time from first page to arrival at the scene	
Ambulance services only: Average scene time - medical	
Ambulance services only: Average scene time - trauma	

Measurable Indicator	Goal	Actual
One full set of vital signs and the GCS will be completed on adult and pediatric patients.	95%	
Multiple, complete sets of vital signs and the GCS will be documented on patients with transportation times greater than 15 minutes.	75%	
Eligible chest pain patients will receive aspirin (ASA) per protocol before transport.	90%	
Suspected stroke patients will receive a neurological examination per protocol.	90%	
Scene time for trauma patients with time critical injuries shall be 10 minutes or less.	90%	
Reason for use of lights & sirens to the scene will be documented	75%	
Reason for use of lights & sirens to the destination will be documented	75%	

Estimating the Dollar Value of Volunteerism					
MULTIPLY columns A x B x C x D = estimated dollar value	A. Average number of responses or meetings per year	B. Average number of hours per response or meeting	C. Average number of personnel per response or meeting	D Estimated value of volunteerism per hour for Iowa*	E. Estimated dollar value of volunteerism for your community
EMS RESPONSES				$17.22	
EMS STANDBY				$17.22	
TRAINING MEETINGS				$17.22	
STAFF MEETINGS				$17.22	
TOTALS					

*The ***Value of Volunteering for States*** website www.volunteeringinamerica.gov lists the value of a volunteer hour in Iowa at $17.22 per hour.